Appendix A

Public Health – Seattle & King County

CHARTING ABBREVIATIONS

A	Assessment
AA	Alcoholics Anonymous
A&W	alive and well
$\bar{a}$	before, prior
ab, Ab, AB	abortion (sp = spontaneous, in = induced)
Abd	abdomen
Abn, abn(l)	abnormal
ABT, Abx	antibiotic
ABW	adjusted body weight
a.c., ac	before meals
ACF	antecubital fossa
ACHES	Abdominal/Chest pain, Headaches, Eye problems, Severe leg pain
AD	right ear
ADA	American Diabetes Association
ADATSA	Alcohol Drug Abuse Treatment and Support Act
ADD	Attention Deficit Disorder
ADHD	Attention Deficit Hyperactivity Disorder
ADL	activities of daily living
ad lib	at discretion, as desired
Adol	adolescent
adm	admitted
AEB	as evidenced by...
AF	atrial fibrillation
AFB	Acid Fast Bacilli
AFP	Alpha-fetoprotein
AGCUS	Atypical glandular cells of undetermined significance

AGH	Auburn General Hospital
AI	artificial insemination
AIDS	Acquired Immune Deficiency Syndrome
AITS	Alcohol Involuntary Treatment Service
AKA	also known as
Alt	Altered
A.M., a.m.	morning (am)
AMA	against medical advice
Amal	amalgam
amb	ambulatory
amox	amoxicillin
amt	amount
Anes	anesthesia
ann	annual
Anon	anonymous
ans	answer
ant	anterior
ANUG	Acute Necrotizing Ulcerative Gingivitis
A+O	alert & oriented
AOB	alcohol on breath
AODM	Adult Onset Diabetes Mellitus
AP	antepartum
A&P	auscultation and percussion
app	apparent/appears
appl	applicator
approx	approximately
appt., appt	appointment
appy	appendectomy

ARC	AIDS Related Complex
ARNP	Advanced Registered Nurse Practitioner
AROM	artificial rupture of membranes
AS	left ear
ASA	acetylsalicylic acid (aspirin)
ASAP	as soon as possible
ASCUS	atypical squamous cells of undetermined significance
ASCVD	arteriosclerotic cardiovascular disease
ASD	atrial septal defect
ASHD	arteriosclerotic heart disease
asx	asymptomatic
AU	both ears
A/V	audio/visual
AV/AF	anteverted/anteflexed
ax	axillary
AZT	azidothymidine
B	booster
BAD	bipolar affective disorder
BBT	basal body temperature
BC	birth control
BCC	benign cellular changes
BCG	Bacillus Calmette-Guerin Vaccine
BCP	birth control pills
BCM	birth control method
BDI	Beck Depression Inventory
BE	barium enema
Beg	beginning
BF	breast-feeding

Bi, BI	bisexual
BID, bid	twice a day
Bilat	bilateral
bkfst	breakfast
BKG	booking
BM	bowel movement
BOM	bilateral otitis media
BP	blood pressure
BPD	bronchopulmonary dysplasia
BPP	biophysical profile
BR, br	breast
BRAT	bananas/rice/apple juice/tea diet
BRBPR	bright red blood per rectum
BS	blood sugar
BSE	breast self-exam
BTB	breakthrough bleeding
BTL	bilateral tubal ligation
BUM	backup method
BUS	Bartholin(s), Urethra, Skene(s)
BV, B vag	bacterial vaginosis
BW	birth weight
BWX	bite wing radiographs
Bx, bx	biopsy
Ca	calcium
CA	cancer
Carp	Carpule
CAT	computerized axial tomography
cath	catheterization
CBC	complete blood count

cc	cubic centimeter
CC	chief complaint
CCMS	Clean catch, mid-stream (urine)
CCU	coronary care unit
CD	complete denture
CDC	Chemical Dependency Counselor
CDP	Community Diversion Program
CF	cystic fibrosis
CHF	congestive heart failure
CHMC	Children's Hospital and Medical Center
CHO	carbohydrate
Chol	cholesterol
CHT	closed head trauma
CIG, cig.	cigarette(s)
CIN	cervical intra-epithelial neoplasia
Circ	circumcision
Cl	clinic
CLSS	community life skills
CLT	client
Cm, cm	centimeter
CMCP	Camphorated paramonochlorophenol
CMT	cervical motion tenderness
CMV	cytomegalovirus
CNM	certified Nurse Midwife
CNS	central nervous system
CO	corrections officer
c/o	complaints of
COC	combination oral contraceptives
COCP	combination oral contraceptive pills

colpo	colposcopy
cont.	continue
cont. mgmt.	contraceptive management
CPD	cephalopelvic disproportion
CPR	cardio-pulmonary resuscitation
CPS	Child Protective Services
CR	Case Report
cryo	cryocautery/surgery
c&s, C&S	culture & sensitivity
C/S	cesarean section (C-section)
CSF	cerebrospinal fluid
CSHCN	Children with Special Health Care Needs
CST	contraction stress test
ct	culture
CT, ct	Chlamydia Trachomatis
Cu 7	Copper 7 IUD
Cu T	Copper T IUD
CV	cardiovascular
CVA	cardiovascular accident, costovertebral angle
CVAT	costovertebral angle tenderness
c/w	case worker
Cx, cx	cervix
CXR	chest x-ray
D	diarrhea
D&C	dilatation and curettage
DC, D/C	discontinue
DD	developmentally delayed

dec	deceased
del	delivery, delivered
DEPO	depo-provera
DES	Diethylstilbesterol
DDS, DMD	dentist
DIS	Disease Intervention Specialist
disc	discussed
disch	discharge
disp	dispense
DLC	difficult life circumstances
DM	diabetes mellitus
DMFT	decayed, missing, filled teeth
DMFS	decayed, missing, filled surfaces
DMPA	depo-provera
DNKA	did not keep appointment
DOB	date of birth
DOPT	directly observed preventive therapy
DOSS	DiOctyl Sodium Sulfosuccinate
DOT	directly observed therapy
doxy, Doxy	Doxycycline
DP	dorsalis pedis
DPT	Diphtheria, Pertussis tetanus
dr	dram
DS	double strength
dschg	discharge
DSHS	Department of Social and Health Services
d/t	due to
DT	Diphtheria, tetanus (Pediatric) (code)
DTP	Diphtheria, tetanus pertussis

DTs	delirium tremens
DV	domestic violence
DWI	driving while intoxicated
Dx	diagnosis
dysp	dysplasia
Dz	disease
E_2	Estrogen
EC	emergency contraceptive
ECC	endocervical curettage
ECG/EKG	electro-cardiogram
ECP	emergency contraceptive pill
ED	Emergency Dept.
EDC	expected date of confinement
EDD	estimated delivery date
EEG	electroencephalogram
EENT	eyes, ear, nose and throat
EES	Erythromycin Ethylsuccinate
EL	early latent (syphilis)
Emerg.	emergent
EMT	Emergency Medical Technician
ENT	ear, nose, and throat
EOM	extraocular movements
ENV	environment
EPT	electric pulp test
EPSDT	early periodic screening diagnosis & treatment
Equil	equilibration
ER	Emergency Room
erythro	erythromycin
ESL	English as 2nd language

ESP	Emergency Service Patrol
esp	especially
ESR	erythrocyte sedimentation rate
ESRD	end stage renal disease
etc.	et cetera
Et. Unk.	etiology unknown
ETOH	alcohol, alcoholic, ethyl alcohol
Eug	eugenol
eval	evaluate, evaluation
exc	excision
ext	extremity
F	Fahrenheit
Fa	father
FAS	fetal alcohol syndrome
F&C	foam and condoms
FBS	fasting blood sugar
Fe	iron
$FeSO_4$	ferrous sulfate
Fem	femoral
FHT	fetal heart tones
FHR	fetal heart rate
Fhx, FH	family history
fib	fibrillation
Fl^-	fluoride
fl	fluid
Fm	family
FNP	Family Nurse Practitioner
FOB	father of baby
FP	family planning

FPC	Family Planning Clinic
FPD	fixed partial denture
FPP	family planning profile (blood tests)
FROM	full range of motion
FSH	follicle stimulating hormone
FTT	failure to thrive
F/U, f/u	follow-up
FUO	fever of unknown origin
Fx, fx	fracture
g	gallop
G&D	Growth and Development
G/P/A	gravida/para/ab
G/P/A/LC	gravida/para/ab/living children
G6PD	glucose-6-phosphate dehydrogenase
GB	gallbladder
GBS	Group B strep
GC	gonorrhea
gf	girlfriend
GGT	gamma-glutamyl dehydrogenase
GI	gastrointestinal
gm	gram
GNID	gram negative intracellular diplococci
GP	General Practitioner
gp	gutta percha
gr	grain
GSW	gunshot wound
GTT	glucose tolerance test
gtts	drops
GU	genitourinary

GYN, Gyn	gynecology
h	hour
HA	headache
Hal	hallucinations
HAV	hepatitis A virus
Hb	hemoglobin
HBIG	hepatitis B immune globulin
HBP	high blood pressure
HBV	hepatitis B virus
HC	hydrocortisone
HCA	Health Care Assistant
HCG (hcg)	human chorionic gonadotropin (preg test)
Hct, HCT	hematocrit
HCTZ	hydrochlorothiazide HCO_3
HCV	hepatitis C virus
HCVD	hypertensive cardiovascular disease
HDL	high-density lipoprotein
HEENT	head, eyes, ears, nose & throat
HEd	health education
Hep	Hepatitis
Hep B	Hepatitis B
HBsAb	Hepatitis B surface antibody
HBsAg	Hepatitis B surface antigen
HGSIL	high grade squamous intraepithelial lesion
HHR	health history reviewed
HIB	hemophilus influenza type B
HI-cal	high caloric
HI-pro	high protein
HI-vit	high vitamin

HIV	human immunodeficiency virus
HMC	Harborview Medical Center
HO	Healthy Options
H/O	history of
H_2O	water
H_2O_2	Hydrogen Peroxide
HOB	head of bed
Hosp	hospital
H&P	history and physical
HPF, hpf	high powered field
HPI	history of present illness
HPV	Human Papilloma Virus
HR	heart rate
hr	hour
hs	bedtime, hr. of sleep
HS	high school
HSG	hysterosalpingogram
HSIL	high grade squamous intraepithelial lesion (HGSIL)
HSV	herpes simplex virus
ht	height
HTN	hypertension
HV	home visit
Hx (hx)	history
I&D	incision and drainage
I&O	intake and output
IC, ic	intercourse
ICU	Intensive Care Unit
ID	intradermally
IDDM	insulin-dependent diabetes mellitus

IDU	injection drug user
IM	intramuscular
I/M	inmate
imm	immunization
imp	impression
INF	influenza
Inf, inf ✓	infection, infection check
INH	isoniazid
init.	initial
IPT	Isoniazid preventive therapy
IRM	Intermediate Restorative Material
IRREG, irreg	irregular
ISG	immune serum globulin
ITS	Involuntary Treatment Services
IUD	intrauterine device
IUG	intrauterine gestation (pregnancy)
IUGR	intrauterine growth retardation
IUP	intrauterine pregnancy
IV	intravenous
IVDU	intravenous drug use/user
IVF	in-vitro fertilization
JDP	Jail Diversion Project
JHS	Jail Health Services
K+	potassium
KCAC	King County Assessment Center
Kcal(s)	calorie(s)
KCl	potassium chloride
Kg	kilogram
KOH	potassium hydroxide

KUB	kidneys, ureters, and bladder
L	left
L_1/L_2/etc.	first lumbar vertebra, second...
LA	left arm subcutaneous (site code)
Lab	laboratory
LAL	left anterolateral thigh (site code)
lap	laparotomy
lat	lateral
LBW	low birth weight
lb(s)	pound(s)
LC	living children
LCR	ligase chain reaction
LD	left deltoid
LDL	low-density lipoprotein
LE	lower extremities
LFT	liver function test
lg	large
LG	left gluteus (site code)
LGA	large for gestational age
LGSIL	low grade squamous intraepithelial lesion (LSIL)
LH	luteinizing hormone
Li_2CO_3	lithium carbonate
liq	liquid
LL	left leg subcutaneous (site code)
LLL	left lower lobe
LLQ	lower left quadrant
LMOM	left message on machine
LMP	last menstrual period
LMTC	left message to call

LNMP	last normal menstrual period
LN_2	liquid nitrogen
LOC	loss of consciousness
LP	lumbar puncture
LSE	last sexual exposure
LSIL	low grade squamous intra-epithelial lesion
LT	left triceps (site code)
LTBI	latent tuberculosis infection
LUOQ	left upper outer quadrant
LUQ	left upper quadrant
LVH	left ventricular hypertrophy
lytes	electrolytes
m	murmur
Mand	mandibular
MAO	monoamine oxidase
MAOI	monoamine oxidase inhibitor
Max	maxillary
M.A.T.(MAT)	morning after treatment
mcg	microgram
MCH	mean corpuscular hemoglobin
MCH	Maternal & Child Health (program)
MCM	maternity case management
MCV	mean corpuscular volume
MD	Medical Doctor
MDI	manic depressive illness
MDRTB	multi-drug resistant tuberculosis

med	medical
meds	medications
mEq	milliequivalent
mg, Mg	milligram
mg_2O_3	Magnesium Oxide
MGF	maternal grandfather
MGM	maternal grandmother
MH	mental health
MHP	Mental Health Professional
MI	myocardial infarction (heart attack)
min	minute
MIO	mentally ill offenders
mix.	mixture
ml	milliliter
mm	millimeter
MMR	measles, mumps, rubella
MN	Masters in Nursing
mo(s), mon	month(s)
Mo	mother
MOB	mother of baby
mod	moderate
Mol. Cont.	Molluscum Contagiosum
MOM	Milk of Magnesia
MOMS+	King County Perinatal Treatment Program
mono	mononucleosis

MOTT	Mycobacterium other than TB
MPC	mucopurulent cervicitis
MPH	Masters in Public Health
MR	medical record
MRI	magnetic resonance imaging
MS	multiple sclerosis
MSE	mental status exam
msg	message
MSM	Men Who Have Sex With Men
msp	multiple sexual partners
MSS	maternity support services
MSW	Masters in Social Work
MSW	Men Who Have Sex With Women (context)
MTB	Mycobacterium tuberculosis
MU	Medical Unit
MVA	motor vehicle accident
N 1/50	Norinyl 1/50
N 1/35	Norinyl 1/35
N/A	not applicable
Na	sodium
NaCl	sodium chloride
NAD	no acute distress
NAI	Native American Indian
Native Am.	Native American

NB	newborn
NBS	normal bowel sounds
NCATS	Nursing Child Assessment Teaching Scale
NCAFS	Nursing Child Assessment Feeding Scale
ND	not done
neg	negative
NG	nasogastric
NGU	non-gonococcal urethritis
NHV	Not home visit
NIDDM	non-insulin dependent diabetes mellitus
NIJ	not in jail
NKA	no known allergy
NKDA	no known drug allergy
nl	normal
noc	night
NP	Nurse Practitioner
NPC	non-productive cough
NPO	nothing by mouth
NR	non-reactive
NRF	North Rehabilitation Facility
NS	normal saline
NSVD	normal spontaneous vaginal delivery
NSAID	non-steroid anti-inflammatory drugs
NSR	normal sinus rhythm
NSSC	normal size, shape, and consistency

NTM	non-tuberculous mycobacterium
N&V	nausea and vomiting
NVD(N/V/D)	nausea, vomiting and diarrhea
NWH	Northwest Hospital
NWKC	Northwest Kidney Center
O	objective
O_2	oxygen
OB	obstetrics
OB-GYN	obstetrics and gynecology
OBS	organic brain syndrome
OC	oral contraceptive
OCP	oral contraceptive pill
OD	right eye
OFC	occipital frontal circumference
OHI	Oral Health instructions
oint	ointment
OM	otitis media
ON 1/50	Ortho Novum 1/50
ON 1/35	Ortho Novum 1/35
OOB	out of bed
OOJ	out of jail
O&P	ova & parasites
OP	outpatient
O.P.D.	outpatient department
OPV	oral polio vaccine

OR	operating room
ORF	oral rehydration fluid
ortho	orthopedics
OS	left eye
OT	occupational therapy
OTC	over-the-counter (medications)
OU	both eyes
OV	office visit
oz	ounces
P	pulse
P:	plan (SOAP note)
P_2	pulmonic second sound
P/M	Paternal/Maternal
PA	periapical
P&A	percussion and auscultation
P&S	protein and sugar
pAb	post abortion
PAC	premature atrial contraction
$PaCO_2$	partial pressure of carbon dioxide in arterial circulation
PAINS	Period late or no period, Abdominal pain, Increased temperature, Not normal vag. Discharge, Spotting between periods
palp	palpation
PaO_2	partial pressure of oxygen in arterial circulation
pan	panoral radiograph
Pap	Papanicolaou smear

Para	number of pregnancies
PARL	periapical radiolucency
PAT	paroxysmal atrial tachycardia
Path	Pathology
Pb	phenobarbital or Ø Barb
pc	after food, after meals
PCN (pcn)	penicillin
PCO	polycystic ovary
pCO_2	carbon dioxide pressure
PCP	primary care provider
PD	postural drainage
pd.	paid
PDA	patent ductus arteriosus
PDL	periodontal ligament
PE	physical exam
ped	pediatric
per	through, by
Periph	peripheral
PERRLA	pupils equal, round react to light and accommodation
PFM	porcelain fused to metal
PGF	paternal grandfather
PGM	paternal grandmother
pH	measure of alkalinity
PHIS	Public Health Info System
PHN	Public Health Nurse

PHSKC	Public Health Seattle & King County
PID	pelvic inflammatory disease
PIH	pregnancy-induced hypertension
PK	peak
PKU	phenylketonuria
PM	post mortem (after death)
P.M., pm	afternoon
PMC	Pacific Medical Center
PMD	private medical doctor
PMHx(PMH)	past medical history
PMNs (polys)	polymorphonuclear leukocytes
PMS	premenstrual syndrome
PNC	prenatal care
PNE	pneumonia
PNP	Pediatric Nurse Practitioner
po	by mouth
pod 10%	Podophyllin 10%
pod 25%	Podophyllin 25%
POIG	Post operative instructions given
POP	popliteal
pos	positive
poss	possible
post	posterior
post-	after
post-op	after surgery

Pot.	Potential
pp	post partum
PPD	purified protein derivative of tuberculin
ppd, p/d	packs per day, or packs/day
PR	per rectum
pre	before
pre-op	pre-operative
pg (preg)	pregnancy
prep	preparation
prn	as needed
Pro	protein
pro	prophylaxis
prob(s)	problem(s)
PROM	Premature Rupture of Membranes
pro time	prothrombin time
PS	pre-school
Pt (pt)	patient
PT	physical therapy
PUD	peptic ulcer disease
PVC	premature ventricular contraction
q	every
q A.M.	every morning
qd	daily
qh	hourly (every hour)
qhs	every night

qid, QID	four times a day
qn	every night
qod	every other day
qs	quantity sufficient
qshift	every shift
Qx	question
R	respiration
R, rt	right
RA, ra	rheumatoid arthritis
RA	right arm subcutaneous (site code)
RAD	Reactive Airway Disease
Rad Pulse	radial pulse
RAL	right anterolateral thigh (site code)
RBC	red blood cell
RCF	root canal filling
RCT	root canal therapy
RD	Registered Dietitian
RD	right deltoid (site code)
R/D	rubber dam
RDA	recommended daily allowance
re:	regards, regarding
re \	re-check
REC, rec	recommend
rec’d	received
ref	refer
reg	regular
re-Pap	repeat Pap smear
rest	restoration (s)
retro	retroverted

RG	right gluteus (site code)
Rh	rhesus factor
RHD	rheumatic heart disease
RICE	rest, ice, compression, elevation
RL	right leg subcutaneous (site code)
RLL	right lower lobe
RLQ	right lower quadrant
RN	Registered Nurse
r/o, R/O	rule out
ROI	release of information
R/T	related to
ROM	range of motion
ROS	review of systems
RPD	removable partial denture
RPR	Rapid Plasma Reagin
RR	respiratory rate
RRR	regular rate, rhythm
RSN	Regional Support Network
RSR	regular sinus rhythm
RT	right triceps (site code)
RTC	return to clinic
rtw	return to work
RUOQ	right upper outer quadrant
RUQ	right upper quadrant
RV	rectovaginal
RV/RF	retroverted/retroflexed
RVG	right ventral gluteal
Rx	prescription
S:	subjective (SOAP note)

SA	sexual activity, sexually active
SAB	spontaneous abortion
SAMS	Substance Abuse Management System
sat	saturate
SEADRUNAR	Seattle Drug and Narcotic Center
scr	screening
SE’s	side effects
SGA	small for gestational age
SGOT	serum glutamic oxalacetic transaminase
SGPT	serum glutamic pyruvic transaminase
SHSA	Senior Health Services Assistant
SI	suicidal ideation, sexual intercourse
Sib	sibling
SIDS	Sudden Infant Death Syndrome
Sig, (sig:)	label (directions)
SIHB	Seattle Indian Health Board
SIL	squamous intraepithelial lesions
SKCDPH	Seattle-King County Dept of Public Health
SKIIS	Sea-King Immunization & Information System
SL	sublingual
sl	slight
sm	small
SMR	submucous resection
SO	significant other
SOAP	subjective, objective, assessment, plan
SOAPIE	subjective, objective, assessment, plan, intervention, evaluation
SOB	short of breath
soln	solution
SOM	serous otitis media

SP	sexual partner
S/P	status post
spec	specimen
spont	spontaneous
SQ	subcutaneous
SrHSA	Senior Health Services assistant
s&s (S&S)	signs and symptoms (S/Sx)
SSC	stainless steel crown
Staph	staphylococcus
STAT	immediately
STD	sexually transmitted disease
STE	soft tissue exam
STS	serologic test for syphilis
SU	Sobering Unit
SubL	sublingual
SUPP (Supp)	suppository
Surg	surgery
SW	Social Worker
Sx	symptom
T	temperature
T&A	tonsillectomy and adenoidectomy
TAB	therapeutic abortion
tab(s)	tablet(s)
TB	tuberculosis
T. Bili	total bilirubin
tbsp.	tablespoon
TC, tc	telephone call
TC	throat culture
T, C, DB	turn, cough, and deep breathe

TCN, tcn	tetracycline
TD (Td)	tetanus, diphtheria (Adult)
TE	tooth extraction (ed)
Temp	temporary
TG	triglycerides
THC	marijuana
THS	Therapeutic Health Services
Thy	thyroid
TIA	transient ischemic attack
tid, TID	three times a day
Tinct	tincture
TKO	to keep open
TLC	tender loving care
TM	tympanic membrane
TMJ	temporomandibular joint
TNTC	too numerous to count
T.O.C.	test of cure
TOP	termination of pregnancy
TPN	total parenteral nutrition
TPPA	type of confirmatory syphilis test
TPR	temperature, pulse, respiration
tr	trace
trans	transportation
Trich	Trichomonas
TSH	Thyroid Stimulating Hormone
tsp.	teaspoon
TWE	tap water enem
Tx	treatment
UA	urinalysis

UBW	usual body weight
UCG	urine pregnancy test
UE	upper extremity
unsat	unsatisfactory
UPI, UPIC	unprotected intercourse
Urg.	urgent
URI	upper respiratory infection
Us, U/S	ultrasound
USR	unheated serum reagent
ut	uterus
UTI	urinary tract infection
UWMC	Univ. of Washington Hosp & Med Ctr
V	vomiting
VA	Veterans Administration
vag	vaginal
Varn	varnish
VBAC	vaginal birth after cesarean
VD	venereal disease
VDRL	Venereal Disease Research Laboratory (test for syphilis)
VF	ventricular fibrillation
VG	ventrogluteal
VMC	Valley Medical Center
V.O.	verbal order
VS	vital signs
VSD	ventricular septal defect
VT	ventricular tachycardia
VVC	vulv/vaginal candidiasis
WB	Western Blot
WBC	white blood cell (count)

W/C	wheel chair
WCC	Washington Correction Center
w/d	withdrawal
WDWN	well-developed, well-nourished
WIC	Women, Infants & Children
wk(s)	week(s)
WNL	within normal limits
WSH	Western State Hospital
WSW	women who have sex with women
wt	weight
wt. mt.	wet mount
W/V	written and verbal
x	times
yel	yellow
yrl	yearly
yrs	years
yo, y/o	year old
znpp	zinc protoporphyrin
ZOE	zinc oxide and eugenol

SYMBOLS

+	positive
↑	increase
σ	change/trimester
↓	decrease
╱	check
°	degree, hours
↑ BP	high blood pressure
↓ BP	low blood pressure
≅	approximately
#	number, pounds
s	without
p̄	after, post
/	per
(R)	rectal
<	less than
≤	less than, or equal to
>	greater than
≥	greater than, or equal to
&	and
@	at
1º	primary
2º	secondary(to)
i	one
ii	two
iii	three
Ø	no, none
Σ	syphilis

PLACES & PROGRAMS

APP	AIDS Prevention Project
APU	AIDS Prevention Unit
Aub CC	Auburn Community Clinic
CHAT	Cedar Hills Alcohol Treatment
CHC	Columbia Health Center
CHMC	Children's Hospital Medical Center
COH	Children's Orthopedic Hospital
CSO	Community Services Office
DOH	Department of Health
DSHS	Department of Social & Health Services
DT Dist.	Downtown District
E Dist.	East District
F.P.	Family Planning
GH	Group Health
GHC	Group Health Cooperative
HD	Health Department
HMC	Harborview Medical Center
ID Clinic	International District Clinic
KC	King County
KCCF	King County Correctional Facility
KCJ	King County Jail
KTC	Kent Teen Clinic
L&I	Labor and Industry
MSS	Maternity Screening Services
No. Dist.	North District
N.S.	Northshore
PHD	Public Health Department

PMC	Pacific Medical Center (Pac Med)
PP	Planned Parenthood
SE Dist.	Southeast District
SFS	State Funded Services
So. – FW	South – Federal Way District
So. – Auburn	South – Auburn District
STD Cl.	Sexually Transmitted Disease Clinic
SW	Southwest District
YES	Youth Eastside Services
UWMC	University of Washington Medical Center
VM	Virginia Mason
VMC	Valley Medical Center

Last Updated: 8-21-98

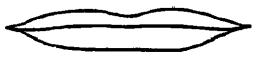
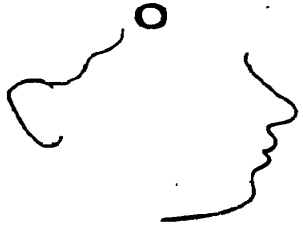
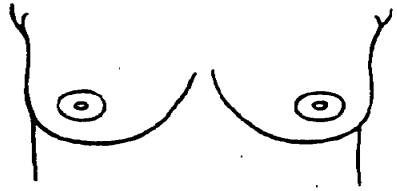
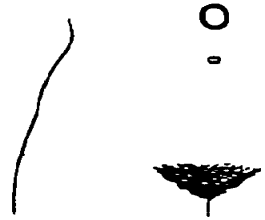
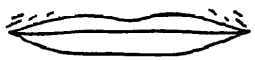
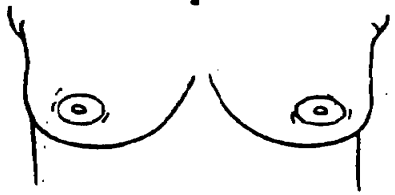
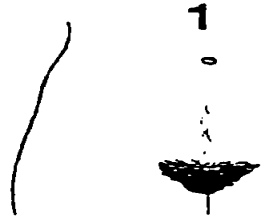
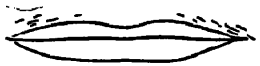
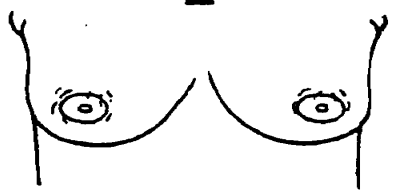
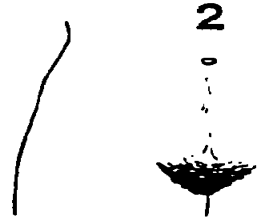
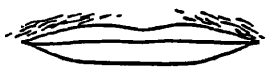
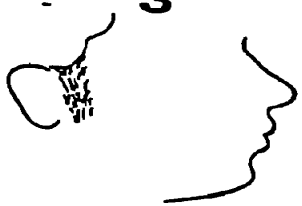
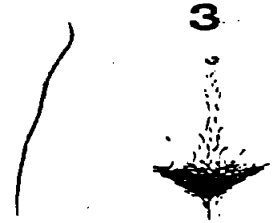
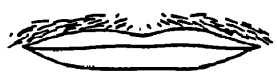
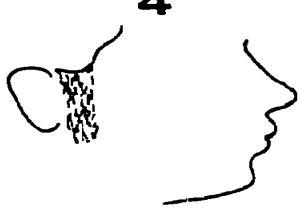
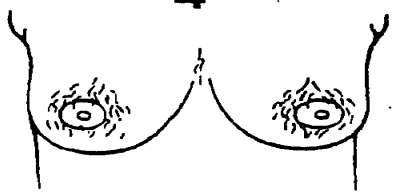
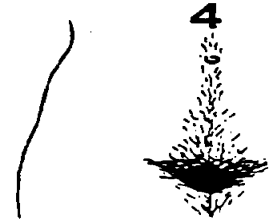
HEIGHT	WEIGHT (pounds)													
	19	20	21	22	23	24	25	26	27	28	29	30	35	40
4'10"	91	96	100	105	110	115	119	124	129	134	138	143	167	191
4'11"	94	99	104	109	114	119	124	128	133	138	143	148	173	198
5'0"	97	102	107	112	118	123	128	133	138	143	148	153	179	204
5'1"	100	106	111	116	122	127	132	137	143	148	153	158	185	211
5'2"	104	109	115	120	126	131	136	142	147	153	158	164	191	218
5'3"	107	113	118	124	130	135	141	146	152	158	163	169	197	225
5'4"	110	116	122	128	134	140	145	151	157	163	169	174	204	232
5'5"	114	120	126	132	138	144	150	156	162	168	174	180	210	240
5'6"	118	124	130	136	142	148	155	161	167	173	179	186	216	247
5'7"	121	127	134	140	146	153	159	166	172	178	185	191	223	255
5'8"	125	131	138	144	151	158	164	171	177	184	190	197	230	262
5'9"	128	135	142	149	155	162	169	176	182	189	196	203	236	270
5'10"	132	139	146	153	160	167	174	181	188	195	202	207	243	278
5'11"	136	143	150	157	165	172	179	186	193	200	208	215	250	286
6'0"	140	147	154	162	169	177	184	191	199	206	213	221	258	294
6'1"	144	151	159	166	174	182	189	197	204	212	219	227	265	302
6'2"	148	155	163	171	179	186	194	202	210	218	225	233	272	311
6'3"	152	160	168	176	184	192	200	208	216	224	232	240	279	319
6'4"	156	164	172	180	189	197	205	213	221	230	238	246	287	328

Cervical Cytology Diagnosis Name Comparison Chart

Histologic Diagnosis	Normal	Reactive, Repair Inflammation, Infection		Condyloma (HPV)	Squamous/Endocervical Dysplasia Endometrial Hyperplasia			Micro-Invasive/ Invasive Carcinoma	
2001 Bethesda	NIL (No Intraepithelial Lesion)		ASCUS	LGSIL		HGSIL or ASCUS HGSIL or AGCUS		SCCA	Unsatisfactory
Bethesda System	Within Normal Limits	Benign Cellular Changes – Infection or Reactive/ Repair	Atypia of Undetermined Significance (ASCUS)	Low Grade Intraepithelial Lesion		High Grade Intraepithelial Lesion		Squamous Carcinoma/ Adeno. CA.	Unsatisfactory
Papanicolaou Class	I	II			III		IV	V	O
Descriptive Diagnosis	Normal Cytology Normal Cervical Cytology Normal Vaginal Cytology Extensive Squamous Metaplasia Endometrial Cells Present Consistent with Menses	Parakeratosis Hyperkeratosis Herpes Actinomyces Bacterial Vaginitis Yeast Trichomonas Radiation Effect	Reactive Squamous Cells Suggestive of Condyloma Cannot Exclude Dysplasia Atypical Endocervical Cells of Undetermined Significance (needs ECC and colposcopy)	Condyloma (HPV)	Mild Squamous Dysplasia (CIN I) Endocervical Dysplasia Endometrials Present, post menopausal (needs endometrial biopsy) Atypical Endometrial Cells (needs endometrial biopsy)	Moderate Squamous Dysplasia (CIN II)	Severe Squamous Dysplasia (CIN IV)	Squamous Carcinoma in Situ (CIN III) Endocervical Adeno-Carcinoma in Situ	Invasive Squamous Carcinoma Micro-Invasive Squamos Carcinoma Endometrial Adeno-Carcinoma Andocervical Adeno-Carcinoma	Unsatisfactory

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

HIRSUTISM CLASSIFICATION

LIP	CHIN	SIDEBURNS	CHEST	ABDOMEN
0 	0 	0 	0 	0 
1 	1 	1 	1 	1 
2 	2 	2 	2 	2 
3 	3 	3 	3 	3 
4 	4 	4 	4 	4 

Adapted from Thomas and Ferriman, 1957

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Last updated: 12/03/02

Juvenile Offenses List

Offense & Citation	Significant Elements (must meet all descriptions)	Presumptive Sentence (1 Count, No Priors)
Rape of a Child First Degree 9A.44.073	Victim under 12 Defendant more than 24 months older Sexual Intercourse	51-68 Months (Class "A" Felony)
Rape of a Child Second Degree 9A.44.076	Victim 12-13 Defendant more than 36 months older Sexual Intercourse	21-27 Months (Class "B" Felony)
Rape of a Child Third Degree 9A.44.079	Victim 14-15 Defendant more than 48 months older Sexual Intercourse	3-9 Months (Class "A" Felony)
Child Molestation First Degree 9A.44.083	Victim under 12 Defendant more than 24 months older Sexual Intercourse	21-27 Months (Class "A" Felony)
Child Molestation Second Degree 9A.44.086	Victim 12-13 Defendant more than 36 months older Sexual Intercourse	12-14 Months (Class "B" Felony)
Child Molestation Third Degree 9A.44.089	Victim 14-15 Defendant more than 48 months older Sexual Intercourse	1-3 Months (Class "C" Felony)
Incest First Degree 9A.64.020 (1)	Victim related to defendant Sexual Intercourse	12 ½ - 14 Months (Class "B" Felony)
Incest Second Degree 9A.64.020 (2)	Victim related to defendant Sexual Contact	6-12 Months (Class "C" Felony)
Sexual Misconduct with a Minor First Degree 9A.44.093	Victim 16-17 Defendant more than 60 months older Defendant in position of authority over victim and abuses authority Sexual Intercourse	1-3 Months (Class "C" Felony)
Sexual Misconduct with a Minor Second Degree 9A.44.096	Victim 16-17 Same as above, except Sexual Contact	Gross Misdemeanor

Sexual Intercourse: Penile/vaginal penetration, penetration by an object, or any contact between mouth, anus, and genitals of another. (Gratification issues don't matter – just looking at whether the event happened).

Sexual Contact: Touching of intimate parts for sexual gratification of either party (can be over-the-clothes touching).

Not Reporting: Gross Misdemeanor

Public Health Seattle and King County
Family Planning Program - Services and Fees
Non-contraceptive Medications and Supplies
August, 2004

Fees:
Fees are set on the number in your family and your family's income. The letters A, B, C, D, and E match your fee category. See the chart to determine your fee based on the service you are requesting.

Family Size	Category A 0 to 100% FPL No Charge	Category B 101% to150% FPL 75% Discount	Category C 151% to 200% FPL 50% Discount	Category D 201% to 250% FPL 25% Discount	Category E 251% + Full Fee
1	0 - $776	$777 - $1164	$1165 - $1552	$1553 - $1940	$ 1,941
2	0 - $1041	$1042 - $1562	$1563 - $2082	$2083 - $2603	$ 2,604
3	0 - $1306	$1307 - $1959	$1960 - $2612	$2613 - $3265	$ 3,266
4	0 - $1571	$1572 - $2357	$2358 - $3142	$3143 - $3928	$ 3,929
5	0 - $1836	$1837 - $2754	$2755 - $3672	$3673 - $4590	$ 4,591
6	0 - $2101	$2102 - $3152	$3153 - $4202	$4203 - $5253	$ 5,254
7	0 - $2366	$2367 - $3579	$3550 - $4732	$4733 - $5915	$ 5,916
8*	0 - $2631	$2632 - $3947	$3948 - $5262	$5263 - $6578	$ 6,579

* For each additional family member add $265 to column A

Non-Contraceptive Medications and Supplies

	A	B	C	D	E
Acyclovir 400 mg, # 30	0	$0.50	$1.00	$1.50	$2
Azithromycin 1 gm, packet	0	$3.75	$7.50	$11.25	$15
Cefpodoxime 200mg, #2	0	$1.25	$2.50	$3.75	$5
Ceftriaxone 250 mg Injection	0	$3.50	$7.00	$10.50	$14
Clotrimazole 1% Vaginal Cream	0	$0.75	$1.50	$2.25	$3
Doxycycline 100 mg, # 14 caps.	0	$0.50	$1.00	$1.50	$2
Doxycycline 100 mg, # 28 tabs	0	$0.50	$1.00	$1.50	$2
Hydrocortisone 1% Topical Cream	0	$0.25	$0.50	$0.75	$1
Ibuprofen 400 mg, #40	0	$0.25	$0.50	$0.75	$1
Lubricating Jelly	0	$0.25	$0.50	$0.75	$1
Medroxyprogesterone 10 mg, # 10	0	$0.25	$0.50	$0.75	$1
Metronidazole 500 mg, # 14	0	$0.50	$1.00	$1.50	$2
Metronidazole 500 mg, # 28	0	$0.50	$1.00	$1.50	$2
Metronidazole 500 mg, #4	0	$0.25	$0.50	$0.75	$1
Miconazole 2% Topical Cream	0	$0.25	$0.50	$0.75	$1
Miconazole 2% Vaginal Cream	0	$0.75	$1.50	$2.25	$3
Naproxen 500 mg, # 30	0	$0.50	$1.00	$1.50	$2
Nitrofurantoin-Macrobid 100 mg, # 6	0	$1.75	$3.50	$5.25	$7
Nitrofurantoin-Macrodantin 50 mg, # 40	0	$0.50	$1.00	$1.50	$2
Penicillin G Benzathine 1.2 mU syr. 2 ml Inj	0	$4.50	$9.00	$13.50	$18
Penicillin G Benzathine 2.4 mU syr. 4 ml Inj	0	$9.00	$18.00	$27.00	$36
Permethrin 1% Cream Rinse	0	$0.50	$1.00	$1.50	$2
Permethrin 5% Topical Cream	0	$1.25	$2.50	$3.75	$5
Phenazopyridine 200 mg, # 6	0	$0.25	$0.50	$0.75	$1
Pyridoxine 50 mg #100	0	$0.25	$0.50	$0.75	$1
Spectinomycin 2gm/5ml Injection	0	$6.00	$12.00	$18.00	$24
Trimethoprim-Sulfa DS, # 14	0	$0.25	$0.50	$0.75	$1
Trimethoprim-Sulfa DS, # 6	0	$0.25	$0.50	$0.75	$1

Pregnancy Screening Form
Instructions for completion

This form was created to serve several purposes:

- To document client interaction when a pregnancy test is performed,
- To provide written information of the pregnancy confirmation visit to an obstetric or abortion provider when the client is referred on for care, and
- To provide pregnancy verification so that the client can apply for Medicaid insurance to cover her ongoing health needs.

Pregnancy testing may occur in one of several places in the Health Department system:

- As part of a Family Planning Clinic visit,
- As part of a Family Health Clinic visit,
- As part of a Maternity Screening office visit to confirm the pregnancy. This may be a scheduled MSS Maternity Screening visit or part of a drop-in Triage screening at a health department site
- As part of a Family Planning/CSO visit at a CSO office
- Or on a home visit provided by a Public Health Nurse.

The following instructions are offered depending on the site or program where the pregnancy test was provided.

1. Family Planning Staff

This form is used by Family Planning program RN and ARNP staff when seeing a client with a positive pregnancy test result. It will replace current documentation. Staff will complete this form and a Family Planning encounter form to document the clinic visit.

Complete as much of the information on the form as you can from information gathered while talking with the client or completing your clinical assessment.

2. Maternity Screening or MSS Staff

It is recommended that all Maternity Screeners or MSS staff that do pregnancy testing use this new form for documenting a positive pregnancy test result. Fill in only those areas of the form that you assess. (You will not be doing a clinical assessment that includes a pelvic exam, so can omit that section.)

The current Pregnancy Verification form that many sites have been using for clients to get on Medicaid does not contain all the information DSHS needs for pregnancy verification. It is recommended that the old form be eliminated and we move to this new form for documentation and verification.
You may choose one of the following methods of documentation depending whether the client is continuing or terminating her pregnancy:

- **Client plans to keep pregnancy**:
  - complete Pregnancy Screening Form so that second (yellow) page can be sent to OB provider (or give to client to take to OB provider); do not need to send AP assessment in addition
  - if you also start an Antepartum Assessment form, do not duplicate charting that may be on Pregnancy Screening form; refer reader to Pregnancy Screening form for information
  - Copy of both AP assessment and Pregnancy Screening form will go in client's medical record
  - Pregnancy Verification (third white page) can be given to client to take to Application Worker or CSO for Medicaid application
  - Complete an FSS Visit Note in order to bill the visit to Program 22.
- **Client plans to terminate pregnancy:**
  - Document pregnancy confirmation on the Pregnancy Screening form; do not start an AP assessment form.
  - Send second (yellow) page to abortion provider (or give to client to take to abortion provider)
  - Pregnancy Verification (third white page) can be given to client to take to Application Worker or CSO for Medicaid application
  - Complete an FSS Visit Note in order to bill the visit to Program 22.

3. Triage Nurse

You may find this form very convenient to document a pregnancy confirmation with a copy to go to the provider of client's choice (OB or abortion provider). The pregnancy verification page (page 3, white in color) can be given to DSHS financial worker or Client Services Specialist at your site to aid in client application for Medicaid.

4. FP/CSO PHN

You may find this form very convenient to document a pregnancy confirmation with a copy to go to the provider of client's choice (OB or abortion provider). The pregnancy verification page (page 3, white in color) can be given to DSHS financial worker to aid in client application for Medicaid. Complete the Pregnancy Screening Form but do not duplicate charting on the FP/CSO Visit Note; refer reader to Pregnancy Screening form for information. (Refer to charting flow sheet for FP/CSO Program re: charting requirements if visit is charged to Program 22 or Program 128).

5. Home Visit PHN

The PHN who does a pregnancy test in the home may find this form helpful. Documentation may depend on whether the client is new to services or an ongoing client.

- If the client has already been receiving PHN services, you may choose to use the FSS Visit Note to document that a pregnancy test was done (Services Provided and Intervention part of SOAPIE note). Referral to OB or abortion provider would be documented in the Intervention part of the SOAPIE note or on the Referral Log.
- If client is new to PHN services and pregnancy test is done as part of the first home visit, use of the Pregnancy Screening Form is a good way to document the pregnancy confirmation, education and referrals made. AP assessment could be deferred until the next home visit. Yellow copy could be sent to provider of client's choice.

Instructions for Completing the Pregnancy Screening Form:

- **Age:** place client's current age in space provided.
- **Gravida:** place the number of times the client has been pregnant in space provided. Include current pregnancy if today's pregnancy test is positive.
- **Para:** place the number of deliveries the client has had in the space provided.
- **SAB:** place the number of spontaneous miscarriages the client has had in the space provided.
- **TAB:** place the number of elective terminations the client has had in the space provided.
- **Living Children:** place the number of living children the client has in the space provided.
- **LMP:** place date of the first day of client's last menstrual period.
- **LNMP:** place date last normal menstrual period began in space provided. This may be the same date as LMP.
- **Date last pregnancy ended:** place the date of the last delivery (or miscarriage, termination) in the space provided.
- **Last Pap:** place date of last Pap smear in space provided.
- **Last BCM used:** indicate the last birth control method that client used.
- **Last UPIC:** place the date of, or number of hours, since last unprotected intercourse in space provided. If pregnancy test is negative, and client wants Emergency Contraception, place the number of hours since last unprotected intercourse in this space.
- **Breastfeeding:** indicate whether client is currently breastfeeding by checking the appropriate box.
- **Complications with previous pregnancies:** indicate complications client had with previous pregnancies. Examples: PIH, gestational diabetes, C section
- **Allergies:** document client allergies; may include medication, pollen or other environmental allergies.
- **Daily medications taken:** document medications client takes.
- **Serious medical problems:** document history of or current medical problems.

- **Pregnancy Sx present?** Document current pregnancy symptoms client is experiencing.
- **Genital infection Sx present?** Document report of current symptoms of genital infection; if symptoms are present, refer client to provider for evaluation.
- **Ectopic risk factors?** Document if client has risk factors for ectopic pregnancy. (PID, past ectopic pregnancy, CT, GC positive). If risk factors are present, refer client to provider for evaluation.
- **STD risk factors?** Document if client has risk factors for STDs. Risk factors are multiple sexual partners, STD in past 6 months, age < 24, history of STDs. If risk factors are present, refer client to provider for evaluation.
- **UCG:** Mark box indicating whether the pregnancy test is positive or negative.
- **Planned Pregnancy:** Check "yes" if pregnancy was planned; check "no" if unplanned.
- **Pregnancy Options discussed:** mark box indicating whether pregnancy options were discussed: adoption, termination or decision to continue pregnancy.
- **Discussed decision/plans:** space is provided for the nurse to document client's decision re: pregnancy and plans.

Referrals: check all the boxes that apply for this visit to document referrals given to the client.

Assess as appropriate: The next section should be assessed if pregnancy test is positive. If counseling or education is provided regarding the topics listed, mark the appropriate box. Check all boxes that apply.

- **Obstetric care services:** mark if discussed OB care and what services are provided as part of OB care
- **Abortion services:** mark if counseled or educated about types of abortions, and services received when choosing a termination of pregnancy.
- **Adoption services:** mark if counseled or educated client about types of adoption, or agencies that provide adoption services.
- **Hot tubs, sauna:** indicate whether client uses hot tubs or sauna. Educate re: risks to fetus of body temperature greater than 104 degrees.
- **Rubella, Hep B, other:** document whether client has been exposed to rubella disease or received immunization during pregnancy, Hepatitis B exposure.
- **Alcohol:** document whether client is using alcohol regularly. Educate re: risks of FAS with even small amounts of exposure to alcohol; consider referral to ADATSA or CD counselor to evaluate use and refer into a treatment program.
- **Substance Use:** document whether client is using any substances; include over the counter, prescription or illegal drugs/substances. Educate re: harmful effects to fetus. Explore readiness for treatment or refer to ADATSA or CD counselor to evaluate use and refer into treatment program.

- **Smoking:** document number of cigarettes client smokes/day if she smokes. Educate re: dangers of smoking during pregnancy (decreased oxygen to fetus, small size, increased risk of SIDS and respiratory problems after birth)
- **X rays:** indicate whether client has had exposure to x-rays during the past few weeks (or during this pregnancy).
- **Domestic Violence:** document if client is experiencing abuse within her relationships. Refer as needed to support or shelter.
- **Animals in household:** assess if client has animals in the household, especially cats. Educate re: changing cat box

Mark the boxes that are appropriate:

- **Vitamins with folate:** mark box if vitamins discussed, given or a prescription for vitamins is given to the client.
- **Handouts:** mark the appropriate box whether handouts are given to the client. Space is provided to document which handout(s) are given.
- **Signature/Date:** signature of the provider who has assessed the items to this point places his/her signature and date of the interaction in the spaces provided.

Boxed area: This section will most likely be used by family planning practitioners who have done a uterine exam and cultures, but if BP and weight are obtained, they may be documented here.

- **Uterus size:** indicate size of uterus by exam
- **BP:** document client blood pressure
- **Weight:** document client weight
- **Tests:** check the boxes of exams done this visit. Indicate results of wet mount test if done
- **Notes:** any additional notes should be written in the space provided.
- **Signature/date:** signature of the family planning provider who has completed the exam and cultures places his/her signature and date of the interaction in the spaces provided.

Pregnancy Verification Section

If client needs to apply for Medicaid for insurance coverage for termination or prenatal care, complete the bottom portion of the form. This serves as verification of pregnancy, which DSHS needs in order to do a Medicaid application.

- **Name:** place client's name in space provided
- **Date:** place date pregnancy test done in space provided (today's date if you saw client today)
- **Gestation:** estimate weeks gestation of the pregnancy, either from dates (LMP) or uterine size (clinical exam).
- **Last Menses (LMP):** place date of last menstrual period in space provided.

- **Pregnancy test (UCG):** mark the box that pregnancy test was positive.
- **EDD:** indicate clients estimated due date in space provided.
- **Please start Medicaid coverage as of:** place date of first appointment that would be covered by Medicaid in the space provided. If client has seen another provider (MSS, medical or family planning) prior to today's visit, use that date. If today's visit is the first medical visit, use today's date.
- **First Steps referral on:** if client wishes to receive First Steps services from the Health Department or other MSS provider, write date referred in space provided. Client can receive both MSS and MCM services if she is continuing the pregnancy or if she chooses to terminate the pregnancy.
- **Signature/Date:** sign your name and place date of service in spaces provided.
- **Label:** place client's name, date of birth and HD patient ID number in boxed space or apply client label. Remember to label all three pages.

Instructions for use of the form:

- **Page one:** place in client's medical record to document visit.
- **Page two (yellow copy):** send to OB or abortion provider or give to client to take to the provider of her choice
- **Page three (white copy):** give verification of pregnancy to client to take to DSHS or Health Department application worker when applying for Medicaid coverage.

Washington State Notifiable Conditions Requirements for Health Care Providers

Conditions (Suspected or Confirmed) Notifiable to Local Health Departments Immediately

Animal Bites
Botulism (Foodborne, infant, and wound)
Brucellosis (*Brucella* species)
Cholera
Diphtheria
Disease of suspected bioterrorism origin (including):
- Anthrax
- Smallpox

Disease of suspected foodborne origin (disease clusters only)
Disease of suspected waterborne origin (disease clusters only)
Enterohemorrhagic *E. coli* such as *E. coli* O157:H7 Infection
Haemophilus influenza (invasive disease, children under age 5)
Hemolytic uremic syndrome
Hepatitis A (acute infection)
Listeriosis
Measles (rubeola)
Meningococcal disease
Paralytic shellfish poisoning
Pertussis
Plague
Poliomyelitis
Rabies (including the use of post-exposure prophylaxis)
Relapsing fever (borreliosis)
Rubella (including congenital rubella syndrome)
Salmonellosis
Shigellosis
Tuberculosis
Typhus
Yellow fever

Other rare diseases of public health significance
Unexplained critical illness or death

Conditions (Confirmed) Notifiable to Local Health Departments within 3 Work Days

Acquired Immunodeficiency Syndrome [AIDS]
Campylobacteriosis
Chancroid
Chlamydia trachomatis infection
Cryptosporidiosis
Cyclosporiasis
Encephalitis, viral
Giardiasis
Gonorrhea
Granuloma inguinale
Hantavirus pulmonary syndrome
Hepatitis B (acute infection)
Hepatitis B surface antigen+ pregnant women
Hepatitis (infectious), unspecified
Herpes simplex, neonatal and genital (initial infection only)
Human immunodeficiency virus (HIV) infection
Legionellosis
Leptospirosis
Lyme Disease
Lymphogranuloma venereum
Malaria
Mumps
Psittacosis
Q Fever
Serious adverse reactions to immunizations
Streptococcus, Group A (Invasive Disease Only)
Syphilis
Tetanus
Trichinosis
Tularemia
Vibriosis
Yersiniosis

Conditions (Suspected or Confirmed) Notifiable to the Department of Health Immediately

Pesticide poisoning (hospitalized, fatal, or cluster)

Conditions (Confirmed) Notifiable to the Department of Health within 3 Work Days

Pesticide poisoning (other)

Conditions (Confirmed) Notifiable to the Department of Health on a Monthly Basis

Asthma, occupational
Birth Defects – Autism
Birth Defects – Cerebral Palsy
Birth Defects – Fetal Alcohol Syndrome/Fetal Alcohol Effects

Conditions (Confirmed) Notifiable to Local Health Departments on a Monthly Basis

Hepatitis B (chronic) – Initial diagnosis, and previously unreported prevalent cases
Hepatitis C – Initial diagnosis, and previously unreported prevalent cases

Washington State Department of Health
Washington State Board of Health
Washington State Department of Labor & Industries

Public Health Seattle and King County
Family Planning Program - Services and Fees
Effective April 1, 2005

Setting Fees in Family Planning:

Family Planning Clinics offer quality, affordable family planning and sexually transmitted disease services. Your fee will be determined on the amount of money you or your family makes, and the number of people supported by this income. Fees are based on a sliding fee schedule. Your fees will cover your visit, lab tests, procedures and supplies. No one will be turned away because they are not able to pay.

We ask that you pay what you can so that our clinic will remain open and continue providing quality family planning services at the lowest possible price. Donations are encouraged.

Fees:
Fees are set on the number in your family and your family's income. The letters A, B, C, D, and E match your fee category. See the chart to determine your fee based on the service you are requesting.

Family Size	Category A 0 to 100% FPL No Charge	Category B 101% to150% FPL 75% Discount	Category C 151% to 200% FPL 50% Discount	Category D 201% to 250% FPL 25% Discount	Category E 251% + Full Fee
1	0 - $798	$799 - $1,197	$1,198 - $1,596	$1,597 - $1,995	$ 1,996
2	0 - $1,069	$1,070 - $1,604	$1,605- $2,138	$2,139 - $2,673	$ 2,674
3	0 - $1,341	$1,342 - $2,012	$2,013 - $2,682	$2,683 - $3,353	$ 3,354
4	0 - $1,613	$1,614- $2,420	$2,421 - $3,226	$3,227 - $4,033	$ 4034
5	0 - $1,884	$1,885 - $2,826	$2,827 - $3,768	$3,769 - $4,710	$ 4,711
6	0 - $2,156	$2,157 - $3,234	$3,235 - $4,312	$4,313 - $5,390	$ 5,391
7	0 - $2,428	$2,429 - $3,642	$3,643 - $4,856	$4,857 - $6,070	$ 6,071
8*	0 - $2,699	$2,700 - $4,049	$4,050 - $5,398	$5,399 - $6,748	$ 6,749

* For each additional family member add $271 to column A

Family Planning Clinic Visit Fees

Services/Fee Category	**A**	**B**	**C**	**D**	**E**
Comprehensive/High					
New (99205)	0	$38	$75	$113	$150
Established (99215)	0	$28	$55	$83	$110
Comprehensive/Moderate					
New (99204)	0	$31	$63	$94	$125
Detailed					
New (99203)	0	$22	$44	$66	$88
Established (99214)	0	$18	$36	$53	$71
Expanded					
New (99202)	0	$15	$30	$44	$59
Established (99213)	0	$12	$25	$37	$49
Problem Focused					
New (99201)	0	$9	$17	$26	$34
Established (99212)	0	$9	$18	$26	$35
Minimal Medical					
Established (99211)	0	$5	$10	$15	$20

10/27/05

Procedure Fees:	**A**	**B**	**C**	**D**	**E**
Colposcopy & Biopsy	0	$22	$44	$66	$88
HIV Pre-Post Test Counseling (per 15 min.)	0	$6	$13	$19	$25
Implant Removal	0	$30	$60	$90	$120
Diaphragm Fitting	0	$14	$29	$43	$57
IUD Insertion	0	$15	$29	$44	$58
IUD Removal	0	$16	$31	$47	$62

Lab Fees:	**A**	**B**	**C**	**D**	**E**
Pap Test	0	$3	$5	$8	$10
Pregnancy (urine)	0	$1	$2	$3	$4
Urine Dipstick/complete	0	$1	$2	$2	$3
Chlymydia Test	0	$0	$0	$0	$0
Gonorrhea Test	0	$0	$0	$0	$0
Herpes Culture	0	$4	$8	$11	$15
HIV Test	0	$2	$5	$7	$9
Blood Draw	0	$1	$1	$2	$2

Supplies:	**A**	**B**	**C**	**D**	**E**
Birth Control Pills (per cycle)	0	$4	$9	$13	$17
IUD-Copper T	0	$84	$168	$252	$336
IUD-LnG	0	$102	$203	$305	$406
Diaphragm	0	$11	$23	$34	$45
Contraceptive Gel	0	$2	$3	$5	$6
Depo-Provera	0	$13	$27	$40	$53
Plan B Emergency Contraception Kit	0	$1	$3	$4	$5
Contracept. Patch, ($4 ea. patch, box of 3)	0	$3	$6	$9	$12
Contraceptive Ring, each	0	$7	$14	$21	$28
Condoms	0	$0	$0	$0	$0

Last updated: 7/26/01

Reproductive Health Access Report

The Reproductive Health Access Report is to document instances in which women have difficulty accessing Family Planning Services. This project could help accurately describe and help fix barriers to reproductive health care. You can help by submitting a report whenever a client tells you she experienced difficulty getting the services she wanted or needed. The data collected may be shared with the State Insurance Commissioner about roadblocks to women receiving reproductive health services.

Name of clinic: _____ Date: _____

Name of person completing this form: _____Telephone #: _____

Type of reproductive health care sought by client:
ρ Abortion ρ Sterilization ρ Pregnancy Screening ρ Other: _____
ρ Family Planning: ρ DMPA injection ρ OCPsρ Other: _____

Information/Referral/Services were refused by: _____

Clients Type of Coverage, if known: ρ ERISA Plan (employer is self insured) ρ Basic Health Plan
ρ Healthy Options ρ DSHS ρ BHP Plus ρ Take Charge ρ Private: _____

Client's Health Benefit Company and Plan, or Clinic, or Provider (include name and address):

_____

With whom did she/you speak? _____

Please provide a detailed description of the woman's experience when attempting to obtain information or a referral for reproductive health services. Describe access problem. Provide dates and details, what brought her to your clinic, and/or how she was unable to obtain reproductive health services.

_____

_____

_____

What other sources of help were sought?
_____

ρ I cannot or do not want to be identified by name or contacted in any form. Please make this an anonymous report.

ρ I understand that this information could be shared with the PHSKC Family Planning Program, the state insurance commissioner, or my health insurance company, and I may be contacted by someone who may try and help fix the problem.

_____
Name Date

_____
Address Phone #1 Phone #2

Please complete the form below and send to Maria Wood; Clinical Services, Family Planning Program; 999 Third Avenue, Suite 1200; Seattle, WA 98104-4039. We will keep a record of the event and if appropriate, forward to the state insurance commissioner's office and/or possibly contact the woman to try and resolve the problem.

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Place Patient Information Sticker Here

Public Health Seattle & King County
Family Planning Program

Client Consent for Emergency Contraception Pills (ECP) by Standing Order

By my signature below, I am indicating that I understand the following information about emergency hormonal contraception:

- My chances of pregnancy following unprotected intercourse are about 1 in 12. Emergency Contraception Pills (ECP) can reduce this risk down to about 1 in 50. I realize that I am not guaranteed that I will not get pregnant and I will hold PHSKC harmless if that occurs.
- ECPs work better the sooner they are taken after unprotected intercourse. The earlier I take the pills, the more effective they will be. If I decide to try ECPs beyond 5 days, I understand the chance of working is a lot less.
- ECPs work like birth control pills, except they are a stronger dose. ECPs prevent pregnancy by blocking ovulation (an egg). ECPs are not an abortion pill and if you are already pregnant they will not work.
- I may have some nausea or even vomiting with this medication.
- Other possible side effects of ECPs include: bleeding, abdominal pain, breast tenderness, headache, dizziness and fatigue.
- I will probably have my next menstrual period within one week before or after the expected time for my period. If I do not have bleeding by 3 weeks from taking the ECP I know I could be pregnant and I will need to return for a pregnancy test.
- If the ECP does not work I know I could be pregnant and very rarely this can be an ectopic or tubal pregnancy and this could be life threatening.
- ECPs do not prevent pregnancy from unprotected sex occurring after the ECP. I should use another form of birth control after using ECP.
- ECPs do not protect me against sexually transmitted diseases (STDs), including HIV.
- ECPs are not known to cause damage to the fetus if used accidentally during early pregnancy.
- I should seek follow-up care if I need ongoing birth control or family planning care, have a delay in my next period of more than one week, suspect that I may be pregnant, or have other reasons for concern.

I have had an opportunity to ask questions and have them answered to my satisfaction. I hereby consent to receiving emergency hormonal contraception (ECP) pills administered by PHSKC.

Date	Signature of Patient
Witness	Interpreter

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Place Patient Information Sticker Here
OR Name & DOB

Salud Pública, Condados de Seattle y King
Programa de Planificación Familiar

Consentimiento de la cliente para Obtener Píldoras Anti-conceptivas de Emergencia (ECP) por Pedido Permanente

Al firmar debajo, indico que entiendo la siguiente información acerca de la anticoncepción hormonal de emergencia:

- Mis probabilidades de embarazo después de haber tenido relaciones sexuales sin protección son alrededor de 1 en 12. Las Píldoras anticonceptivas de Emergencia (ECP) pueden reducir este riesgo hasta alrededor de 1 en 50. Entiendo que no se me garantiza que no quedaré embarazada y mantendré a PHSKC indemne si eso sucediera.
- Las ECPs funcionan mejor mientras más pronto se tomen después de una relación sexual sin protección. Mientras más pronto tome las píldoras, más eficaces serán. Si decido tratar de tomar las ECPs después de 5 días, entiendo que la probabilidad de que funcionen será mucho menor.
- Las ECPs funcionan como píldoras de control de la natalidad, excepto que son una dosis más fuerte. Las ECPs previenen el embarazo bloqueando la ovulación (un óvulo). Las ECP no son píldoras abortivas y si usted ya está embarazada estas no funcionarán.
- Yo podría sentir algo de nauseas o incluso vómitos con este medicamento.
- Otros efectos colaterales posibles de las ECP incluyen: sangrado, dolor abdominal, sensibilidad en los senos, dolor de cabeza, mareo y fatiga.
- Probablemente tenga mi próximo periodo menstrual dentro de una semana antes o después del momento esperado de mi periodo. Si no tengo sangrado hasta 3 semanas después de haber tomado las ECP, entiendo que podría estar embarazada y tendré que volver para un examen de embarazo.
- Si las ECP no funcionan, sé que podría estar embarazada y que muy rara vez podría tratarse de un embarazo ectópico o en las trompas de Falopio y que esto puede ser crítico.
- Las ECP no previenen el embarazo a consecuencia de relaciones sexuales sin protección que ocurrieron después de haber tomado las ECP. Debo utilizar otra forma de control de la natalidad después de utilizar las ECP.
- Las ECP no me protegen contra las enfermedades transmitidas sexualmente, incluyendo el VIH.
- Las ECP no son causa conocida de daño al feto si se utilizan accidentalmente durante el comienzo del embarazo.
- Debo buscar atención complementaria si necesito control de la natalidad en forma continua o atención de planificación familiar, si tengo un retraso en mi próximo período de más de una semana, sospecho que podría estar embarazada, o si tengo otros motivos de preocupación.

He tenido la oportunidad de hacer preguntas y las han respondido a mi satisfacción. Por el presente, consiento en recibir las píldoras de anticoncepción hormonal de emergencia (ACP) administradas por PHSKC.

Fecha	Firma de la paciente
Testigo	Intérprete

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Place Patient Information Sticker Here
OR Name & DOB

Public Health Seattle & King County
Family Planning Program

Client Consent for Emergency Contraception Pills (ECP) by Standing Order

By my signature below, I am indicating that I understand the following information about emergency hormonal contraception:

- My chances of pregnancy following unprotected intercourse are about 1 in 12. Emergency Contraception Pills (ECP) can reduce this risk down to about 1 in 50. I realize that I am not guaranteed that I will not get pregnant and I will hold PHSKC harmless if that occurs.
- ECPs work better the sooner they are taken after unprotected intercourse. The earlier I take the pills, the more effective they will be. If I decide to try ECPs beyond 5 days, I understand the chance of working is a lot less.
- ECPs work like birth control pills, except they are a stronger dose. ECPs prevent pregnancy by blocking ovulation (an egg). ECPs are not an abortion pill and if you are already pregnant they will not work.
- I may have some nausea or even vomiting with this medication.
- Other possible side effects of ECPs include: bleeding, abdominal pain, breast tenderness, headache, dizziness and fatigue.
- I will probably have my next menstrual period within one week before or after the expected time for my period. If I do not have bleeding by 3 weeks from taking the ECP I know I could be pregnant and I will need to return for a pregnancy test.
- If the ECP does not work I know I could be pregnant and very rarely this can be an ectopic or tubal pregnancy and this could be life threatening.
- ECPs do not prevent pregnancy from unprotected sex occurring after the ECP. I should use another form of birth control after using ECP.
- ECPs do not protect me against sexually transmitted diseases (STDs), including HIV.
- ECPs are not known to cause damage to the fetus if used accidentally during early pregnancy.
- I should seek follow-up care if I need ongoing birth control or family planning care, have a delay in my next period of more than one week, suspect that I may be pregnant, or have other reasons for concern.

I have had an opportunity to ask questions and have them answered to my satisfaction. I hereby consent to receiving emergency hormonal contraception (ECP) pills administered by PHSKC.

Date	Signature of Patient
Witness	Interpreter

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Place Patient Information Sticker Here
OR Name & DOB

Sở Y Tế Công Cộng Seattle & Quận King
Chương Trình Kế Hoạch Gia Đình

Thân Chủ Ưng Thuận Dùng Thuốc Viên Ngừa Thai Khẩn Cấp (ECP) bằng Chỉ Thị Thường Trực

Khi ký tên dưới đây, tôi cho thấy rằng tôi hiểu các thông tin sau đây về ngừa thai khẩn cấp bằng kích thích tố:

- Xác suất tôi mang thai sau khi giao hợp không phòng ngừa là khoảng 1 phần 12. Thuốc Viên Ngừa Thai Khẩn Cấp (ECP) có thể giảm xác suất này xuống còn khoảng 1 phần 50. Tôi biết rằng không thể bảo đảm là tôi sẽ không mang thai và tôi không bắt PHSKC phải chịu trách nhiệm nếu tôi mang thai.
- ECP càng dễ có hiệu quả hơn khi dùng càng sớm càng tốt sau khi giao hợp không phòng ngừa. Tôi càng dùng thuốc sớm bao nhiêu thì càng có hiệu quả bấy nhiêu. Nếu tôi quyết định dùng thử ECP sau 5 ngày, tôi hiểu rằng cơ hội để thuốc có tác dụng bị giảm đi nhiều.
- ECP tác động như thuốc viên ngừa thai, nhưng với liều lượng mạnh hơn. ECP ngừa thai bằng cách ngăn chặn trứng rụng (trứng). ECP không phải là thuốc phá thai và nếu quý vị đã có thai thì thuốc này sẽ không có hiệu quả.
- Tôi có thể cảm thấy buồn nôn hoặc thậm chí ói mửa khi dùng thuốc này.
- Các phản ứng phụ khác của ECP có thể gồm: ra máu, đau bụng dưới, đau vú, nhức đầu, chóng mặt và mệt mỏi.
- Tôi có thể sẽ có kinh vào lần tới trong vòng một tuần trước hoặc sau ngày dự liệu có kinh. Nếu tôi không có kinh sau 3 tuần kể từ khi uống ECP thì tôi biết là tôi có thể có thai và tôi cần trở lại để thử thai.
- Nếu ECP không có hiệu quả thì tôi biết rằng tôi có thể có thai và trường hợp này có thể là mang thai ngoài tử cung hoặc có thai trong vòi trứng tuy rất hiếm khi xảy ra và có thể đe dọa đến mạng sống.
- ECP không ngừa thai được nếu giao hợp không phòng ngừa sau khi dùng ECP. Tôi nên dùng một phương pháp ngừa thai khác sau khi dùng ECP.
- ECP không bảo vệ tôi khỏi những căn bệnh phong tình (STD), kể cả HIV.
- ECP được biết là không tác hại đến thai nhi nếu vô ý dùng thuốc này khi mới có thai.
- Tôi nên xin tái khám nếu tôi cần ngừa thai liên tục hoặc cần chăm sóc kế hoạch gia đình, bị chậm kỳ kinh kế tiếp hơn một tuần, nghi ngờ tôi có thể có thai, hoặc có các lý do quan ngại khác.

Tôi đã có cơ hội nêu thắc mắc và được giải đáp thỏa đáng. Tôi theo đây ưng thuận dùng thuốc viên ngừa thai khẩn cấp bằng kích thích tố (ECP) do PHSKC cung cấp.

Ngày	Chữ Ký Bệnh Nhân
Nhân Chứng	Thông Dịch Viên

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Place Patient Information Sticker Here
OR Name & DOB

Public Health Seattle & King County
Family Planning Program

Client Consent for Emergency Contraception Pills (ECP) by Standing Order

By my signature below, I am indicating that I understand the following information about emergency hormonal contraception:

- My chances of pregnancy following unprotected intercourse are about 1 in 12. Emergency Contraception Pills (ECP) can reduce this risk down to about 1 in 50. I realize that I am not guaranteed that I will not get pregnant and I will hold PHSKC harmless if that occurs.
- ECPs work better the sooner they are taken after unprotected intercourse. The earlier I take the pills, the more effective they will be. If I decide to try ECPs beyond 5 days, I understand the chance of working is a lot less.
- ECPs work like birth control pills, except they are a stronger dose. ECPs prevent pregnancy by blocking ovulation (an egg). ECPs are not an abortion pill and if you are already pregnant they will not work.
- I may have some nausea or even vomiting with this medication.
- Other possible side effects of ECPs include: bleeding, abdominal pain, breast tenderness, headache, dizziness and fatigue.
- I will probably have my next menstrual period within one week before or after the expected time for my period. If I do not have bleeding by 3 weeks from taking the ECP I know I could be pregnant and I will need to return for a pregnancy test.
- If the ECP does not work I know I could be pregnant and very rarely this can be an ectopic or tubal pregnancy and this could be life threatening.
- ECPs do not prevent pregnancy from unprotected sex occurring after the ECP. I should use another form of birth control after using ECP.
- ECPs do not protect me against sexually transmitted diseases (STDs), including HIV.
- ECPs are not known to cause damage to the fetus if used accidentally during early pregnancy.
- I should seek follow-up care if I need ongoing birth control or family planning care, have a delay in my next period of more than one week, suspect that I may be pregnant, or have other reasons for concern.

I have had an opportunity to ask questions and have them answered to my satisfaction. I hereby consent to receiving emergency hormonal contraception (ECP) pills administered by PHSKC.

Date	Signature of Patient
Witness	Interpreter

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Place Patient Information Sticker Here
OR Name & DOB

Emergency Contraception by Standing Order
Service Log & Chart Review Guide

Performing a review of our service logs and charts is a standard procedure for assuring compliance with the Emergency Contraception by Standing Order protocols and documentation standards set forth by the Family Planning Program. For quality assurance purposes we suggest performing a service review on an annual basis using the following tools.

Emergency Contraception by Standing Order Service Log Review Instructions

Select 5 pages of service log entries completed during the time period selected for the audit. (Each page has 7 service lines so this could include up to 35 clients). If you have less than 5 pages in the time period, review them all.

Note: If there are more than 5 pages choose every other page until you have 5. Choose every 3rd page if there are 15 or more. If more than one PHN is regularly giving EC at the site, review 5 pages per nurse.

Emergency Contraception by Standing Order Chart Review Instructions

Select 5 charts for each nurse regularly providing ECPs by standing order at the CSO or at PHSKC sites.

1. Make a copy of the Service Log covering the time period selected for review. (If 5 services log pages were selected for the Service Log audit, use these same pages to select charts for review.)

2. Select EC charts to be reviewed. If 5 or fewer clients were seen for EC during this time, review all 5 client records. Select every other EC client from the log if 10 or fewer were seen. Select every 3rd EC client if 15 or more were seen. On the FP PHN Chart Review Check List, record the service date and client's initials. If a chart is not found note "chart not found" next to client's initials at the top of the form. **Do not pull another chart.**

3. Do chart review. (It is best if nurses do not review their own charts. Consider including your supervisor in the review or join with another PH site or with other CSO nurses for the review.)

4. Circle YES or No for each question. Provide details in note section if directed or needed. Indicate if anything is missing such as any of the forms or the chart itself. Part of the audit is to identify and correct any systems issues as well as to assure quality of practice.

5. Include the copy of your service logs with the completed Chart Review.

6. Completed Chart Review materials can be given FP-CSO program staff or to your supervisor and filed with your other locked EC supplies and log.

7. If you have questions call June Hooper at (206) 296-4918, or Melinda Read at (206) 296-4673.

Emergency Contraception by Standing Order Service Log Check List

Service Dates Being Review: _____

CSO or PHSKC Site: _____ PHN(s):_____

Review Date: _____ Review completed by:_____

Items for review: *Please indicate the number of completed items for each page of entries such as 6/7 meaning the item was completed for 6 out of 7 service lines.*

# Service Log Pages Reviewed:	**#1**	**#2**	**#3**	**#4**	**#5**	**Total**	**Comments:**
Items for review: (usually 7 entries per page)							
1. Service date documented							
2. Client name documented							
3. DOB documented							
4. EC pharmacy label attached if EC given & 2 labels attached if 2 packs given?							
5. Dispensing plan for EC marked on the log?							
6. Pregnancy test lot number recorded at least once per page.							
7. PHN initials are included on each service line.							
8. PHN signature present at the bottom of the page for each nurse initialing a service?							

ECP Client Log Review (*Items for review – using the same 5 service log pages answer the following questions.)*	**#**	**Comments:**
9. Number of clients getting EC?		
10. Number of clients getting emergent EC?		
11. Number of clients getting emergent EC who also got advanced EC?		Standard = 100%
12. Number of clients getting emergent EC who also got a pregnancy test?		Standard = 100%
13. If a pregnancy test was not done for emergent EC, pull the chart and note the reason.		

Emergency Contraception by Standing Order Chart Review Check List

CSO or PHSKC Site _____ ***Client Initials only_____***
(Use one form per chart)
Reviewer(s): **Date of Review _____**
1.
2.

Circle "Yes" or "No" for each item below

EC Standing Order Chart Form

1. EC for Emergent Use:

Was ECP given for emergent use? **Yes** **No**

If yes:

- The hours from UPIC are documented? **Yes** **No**
- Was a pregnancy test also done? **Yes** **No**
- If a pregnancy test was not done, was the reason documented? **Yes** **No**

  What was the reason:_____
- Was a second (future) pack of EC also given? **Yes** **No**

2. EC for Future Use:

If EC was given for future use, was only *one* pack given. **Yes** **No**

General Questions:

3. Client's current BCM is documented. **Yes** **No**
4. Was birth control plan discussed and documented? **Yes** **No**
5. Was birth control method choice documented? **Yes** **No**
6. PHN's signature and date is documented. **Yes** **No**
7. Patient name and birth date is documented in patient information box. **Yes** **No**

PHSKC Consent for Treatment

8. The consent form is signed. **Yes** **No**

Client Consent for Emergency Contraception Pills (ECP) by Standing Order

9. The EC Consent form is signed. **Yes** **No**

Other follow up or comments: _____
Notes:

Below is a sample of a completed Service Log Review form.

SAMPLE:

Emergency Contraception by Standing Order Service Log Check List

# Service Log Pages Reviewed	#1	#2	#3	#4	#5	Total	Comments:
Items for review: (usually 7 entries per page)							
1. Service date documented	7/7	7/7	7/7	6/7	7/7	34/35	Completed 97% -34 out of 35 entries
2. Client name documented	7/7	7/7	7/7	7/7	7/7	35/35	Completed 100%
3. DOB documented	6/7	7/7	7/7	7/7	7/7	34/35	Completed 97% - 34 of 35 entries
4. EC pharmacy label attached if EC given & 2 labels attached if 2 packs given?	7/7	7/7	7/7	7/7	7/7	35/35	
5. Dispensing plan for EC marked on the log.	Yes	Yes	Yes	Yes	Yes	Yes	100%
6. Pregnancy test lot number recorded at least once per page.	Yes	Yes	No	Yes	Yes	4/5	Indicated on 4 of 5 pages or 80%
7. PHN initials are included on each service line.	7/7	7/7	7/7	7/7	7/7	35/35	100%
8. PHN signature present at the bottom of the page for each nurse initialing a service.	No	Yes	Yes	Yes	Yes	4/5	Present on 4 of 5 pages or 80%

ECP Client Log Review (Using the same 5 service log pages answer the following questions.)	#	**Comments:**
9. Number of clients getting EC?	20	
10. Number of clients getting emergent EC?	10	
11. Number of clients getting emergent EC who also got advanced EC?	10	Standard = 100%
12. Number of clients getting emergent EC who also got a pregnancy test?	10	Standard = 100%
13. ***If a pregnancy test was not done for emergent EC, pull the chart and note the reason.***		Comments….

Emergency Contraception by Standing Order Chart Review Follow-up

Please review the results of the emergency contraception by standing order chart review. Overall the results were good. Based on the issues noted below we recommend a second review of the following charts. Our intention is to identify problems in documenting services and to get client records processed and filed in an accurate and timely manner.

CSO or PHSKC Site _____

Date of Review _____ ***Reviewed by:***_____
(Name(s) and Title

Issues Noted:

1.

2.

3.

Chart(s) For Follow-up and Second Review: ***(Client name(s) and DOB)***

Action: (make more copies of this form if needed to document action or comments)

Follow up by:_____ **Date** _____
Name(s) and Title

Review of follow up by: _____ **Date**_____
Name (s) and Title

Return to Family Planning Program Administration (For FP-CSO Program send to Melinda Read or June Hooper).

Rev 7/7/05

Emergency Contraception Standing Order Chart Form

S: AGE _____ G _____ P _____ SAB _____ TOP _____ LC _____ Lactating: ❑ Yes ❑ No

1. Current BCM: _____
   Allergies: _____ Regular Medications: _____
2. Reason for ECP (Note: If client is currently pregnant, ECP may be given for future use)
   - ❑ Possible future need because of future birth control method failure
   - ❑ Emergent need (complete #3 below): ❑ condom broke ❑ missed OCPs ❑ method not used correctly ❑ no method used ❑ other: _____
3. LMP: _____ Cycle day since LMP when first UPIC occurred: _____
   Coital Hx: Hours since UPIC ❑ <24 ❑ 24-48 ❑ 49-72 ❑ 73-120 ❑ >120 (not effective)
   Multiple UPIC ❑ No ❑ Yes

O: UCG: ❑ Negative ❑ Positive ❑ Not done (check reason below and/or explain): _____

❑ Advanced provision of EC for use after current pregnancy ends ❑ Advanced provision of EC for birth control back up

Blood Pressure (optional): _____

A: Candidate for ECP: ❑ No ❑ Yes, ❑ Emergent Need and/or ❑ Future Possible Need

P:
- ❑ Meets criteria and standing order protocol used.
- ❑ Levonorgestrel 750 mcg pill, one po STAT and then repeat in exactly 12 hours.
- ❑ Levonorgestrel 750 mcg pill, two pills po STAT now because the client prefers single dose rather than divided dose timing of the Lng ECP (this option can not be used for Yutzpe or combination OCP ECP).
- ❑ Two Levonorgestrel 750 mcg pills for future use; to take one and repeat in 12 hours, within 120 hours following future UPIC or method failure or 2 pills taken together at one time if client prefers (only one package for future use is to be dispensed at a time).
- ❑ Other: _____

COUNSELING PROVIDED:
- ❑ ECP risk, benefits and side effects discussed.
- ❑ If vomits 2 hours from ingestion (< 5% risk of this) client needs to repeat both pill doses. (Advise client to call her PCP or a pharmacist if she has questions or concerns.)
- ❑ Advised to call for clinic appointment after future ECP use (to assess birth control needs).
- ❑ Advised about STD prevention, condoms, and importance of STD screening.
- ❑ Advised if no bleeding in 3 weeks pregnancy likely and could be ectopic so needs to see a provider or clinic.
- ❑ Birth control plan discussed.
- ❑ Contraception method desired: _____
- ❑ If contraceptive method requires prescription then referred to PHSKC clinic _____ for family planning services or reason not done: _____

NOTES: _____

PHN Name _____ ❑ PHN current and trained for ECP Standing Orders

PHN Signature _____ **Date** _____

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Last updated: 04/20/05

Place Patient Information Sticker Here
OR Name & DOB

Emergency Contraceptive Standing Order Policy

Background

To provide increased access to ECP when clients are not located in a clinic site, an RN staff can be trained to provide ECP under a standing order. To develop this program the nursing and pharmacy administrative codes were searched to ascertain the definitions under which a standing order could operate. These are listed below. In summary as long as there exists a formal protocol an RN under the general direction of a licensed provider may administer or dispense a contraceptive medication.

The nursing practice act was searched at http://search.leg.wa.gov/wslrcw and the following regulations are listed below to describe nursing practice:

Chapter 18.79 RCW Nursing Care. Under this general list the following items pertained to our development of standing orders for the prescribing and dispensing of hormonal contraceptives.

RCW 18.79.010 Purpose. It is the purpose of the nursing care quality assurance commission to regulate the competency and quality of professional health care providers under its jurisdiction by establishing, monitoring and enforcing qualifications for licensing, consistent standards of practice, continuing competency mechanisms and discipline. Rules, policies and procedures developed by the commission must promote the delivery of quality health care to the residents of the state of Washington.

RCW 18.79.280 Medication, tests treatments allowed. It is not a violation of chapter 18.71 RCW or of chapter 18.57 RCW for a registered nurse, at or under the general direction of a licensed physician and surgeon, or osteopathic physician and surgeon, to administer prescribed drugs, injections, inoculations, tests, or treatment whether or not the piercing of tissues is involved.

RCW 18.79.040 "Registered nursing practice" defined – Exceptions.
"Registered nursing practice" means the performance of acts requiring substantial specialized knowledge, judgment and skill based on the principles of the biological, physiological, behavioral and sociological sciences in either:

a) The observation, assessment, diagnosis, care or counsel and health teaching of the ill, injured, or infirm, or in the maintenance of health or prevention of illness of others;
b) The performance of such additional acts requiring education and training and that are recognized by the medical and nursing professions as proper and recognized by the commission to be performed by registered nurses licensed under this chapter and that are authorized by the commission through its rules;
c) The executing of medical regimen as prescribed by a licensed physician and surgeon, dentist, osteopathic physician and surgeon, podiatric physician and surgeon, physician assistant, osteopathic physician assistant, or advanced registered nurse practitioner.

RCW 18.79.260 Registered nurse – Activities allowed – Delegation of tasks.
1. A registered nurse under his or her license may perform for compensation nursing care, as that term is usually understood, of the ill, injured, or infirm.
2. A registered nurse may, at or under the general direction of a licensed physician and surgeon, dentist, osteopathic physician and surgeon, naturopathic physician, podiatric physician and surgeon, physician assistant, osteopathic physician assistant, or advanced registered nurse practitioner acting within the scope of his or her license, administer medications, treatments, tests and inoculations, whether or not the severing or penetrating of tissues is involved and whether or not a degree of independent judgment and skill is required. Such direction must be for acts, which are within the scope of registered nursing practice.

RCW 69.41.010 Definitions. In the *Pharmacy Lawbook - Washington State Dept. of Health Board of Pharmacy* text in the chapter titled: Legend Drugs – Prescription Drugs (Chapter 69.41, page 1-3), the following terms have the meanings indicated unless the text clearly requires otherwise:

1. "Administer" means the direct application of a legend drug whether by injection, inhalation, ingestion, or other means, to the body of a patient or research subject:
   a) A practitioner; or
   b) The patient or research subject at the direction of the practitioner.
2. "Deliver" or "delivery" means the actual, constructive, or attempted transfer from one person to another of a legend drug, whether or not there is an agency relationship.

3. “Department” means the department of health.

4. “Dispense” means the interpretation of a prescription or order for a legend drug and, pursuant to that prescription or order, the proper selection, measuring, compounding, labeling, or packaging necessary to prepare that prescription or order for delivery.

5. “Dispenser” means a practitioner who dispenses.

6. “Distribute” means to deliver other than by administering or dispensing a legend drug.

7. “Distributor” means a person who distributes.

8. “Drug” means:
   a) Substances recognized as drugs in the official United States pharmacopoeia, official homeopathic pharmacopoeia of the United States, or official national formulary, or any supplement to any of them;
   b) Substances intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in man or animals;
   c) Substances (other than food, minerals or vitamins) intended to affect the structure or any function of the body of man or animals; and
   d) Substances intended for use as a component of any article specified in clause (a), (b), or (c) of this subsection. It does not include devices or their components, parts, or accessories.

9. “Legend drugs” means any drugs, which are required by state of law or regulation of the state board of pharmacy to be dispensed on prescription only or are restricted to use by practitioners only.

10. “Person” means individual, corporation, government or governmental subdivision or agency, business trust, estate, trust, partnership or association, or any other legal entity.

11. “Practitioner” means:
    - A physician under chapter 18.71 RCW, an osteopathic physician or an osteopathic physician and surgeon under chapter 18.57 RCW, a dentist under chapter 18.32 RCW, a podiatric physician and surgeon under chapter 18.22 RCW, a veterinarian under chapter 18.92 RCW, a registered nurse, advanced registered nurse practitioner, or licensed practical nurse under chapter 18.79 RCW, an optometrist under chapter 18.53 RCW who is certified by the optometry board under RCW 18.53.010, an osteopathic physician assistant under chapter 18.57A RCW, a physician assistant under chapter 18.71A RCW, or a pharmacist under chapter 18.64 RCW.

RCW 69.41.050 Labeling requirements. To every box, bottle, jar, tube or other container of a legend drug, which is dispensed by a practitioner authorized to prescribe legend drugs, there shall be affixed a label bearing the name of the prescriber, complete directions for use, the name of the drug either by the brand or generic name and strength per unit dose, name of patient and date: PROVIDED, that the practitioner may omit the name and dosage of the drug if he determines that his patient should not have this information and that, if the drug dispensed is a trial sample in its original package and which is labeled in accordance with federal law or regulation, there need be set forth additionally only the name of the issuing practitioner and the name of the patient.

Public Health Seattle & King County
Family Planning Program

Emergency Contraception Standing Order Signature Page

Title: Screening and counseling protocol for dispensing emergency hormonal contraception with standing orders for administration.

Original Signed Copy is on File	**7/31/03**
Responsible Prescribing Authority (Licensed Physician Signature)	Date

Original Signed Copy is on File	**7/31/03**
Approved by Medical Director (Signature)	Date

Policy

- Emergency (hormonal) contraceptive pills (ECPs) are an important option for women who have recently had unprotected intercourse or a contraceptive accident and who do not want to become pregnant.

- Offering emergency contraception is an important way by which family planning and reproductive health programs can improve the quality of their services and better meet the needs of their clients.

- Providing emergency contraceptive information and, if possible, supplies at the time of another contact with local health jurisdiction staff is one way of ensuring that women have the resources they need to protect themselves from pregnancy in the event of unprotected intercourse or contraceptive accident.

- An RN and with formal training as documented by the ECP Training Form may dispense 1 to 2 packages of Plan B using the ECP Standing Order Documentation Form, the PHSKC department dispensing guidelines, the ECP Consent Form, and the ECP guidelines as specified in the PHSKC Family Planning EC guidelines. This program will be evaluated annually with the ECP Standing Orders Program Review Procedure and Chart Review Form.

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

CSO Site:_____________

Family Planning CSO PHN Service Log

Date	Client Name	DOB	ECP Future Pack	Plan B Given Emerg	Dosage Plan	Pregnancy UCG Test *Circle result*	Lot # *for UCGs*	EC label	PHN Initials
					☐ 2 Pills ☐ Divided Dose	***Pos*** ***Neg*** ***Not Done***			
					☐ 2 Pills ☐ Divided Dose	***Pos*** ***Neg*** ***Not Done***			
					☐ 2 Pills ☐ Divided Dose	***Pos*** ***Neg*** ***Not Done***			
					☐ 2 Pills ☐ Divided Dose	***Pos*** ***Neg*** ***Not Done***			
					☐ 2 Pills ☐ Divided Dose	***Pos*** ***Neg*** ***Not Done***			
					☐ 2 Pills ☐ Divided Dose	***Pos*** ***Neg*** ***Not Done***			
					☐ 2 Pills ☐ Divided Dose	***Pos*** ***Neg*** ***Not Done***			

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Initial Signature
_______ _____________
Inital Signature
_______ _____________

Initial Signature
_______ _____________
Intial Signature
_______ _____________

Keep log for 3 years.

PHN Site Specific Instructions for Emergency Contraception

1. The public health nurse at: _____CSO will follow the Emergency Contraception Guidelines found in the PHSKC Family Planning Guidelines and CSO PHN Family Planning Notebook which is located _____.
2. The client will complete a registration form and a standard consent form.
3. The nurse will complete the S/O portion of the Emergency Contraception Verbal Order Chart Form.
4. The PHN will follow the plan below for obtaining an Emergency Contraception Verbal Order. (**Please check one**)
   - ρ The PHN will fax the Emergency Contraception Verbal Order Chart form to _____ clinic at _____fax # before calling _____# and requesting to speak to _____ or _____ to obtain a Verbal Order.
   - ρ The PHN will call _____ clinic at _____# and ask for _____ or _____ for a telephone consultation and verbal order for **each** candidate for Emergency Contraception.
   - ρ The PHN will consult with _____ or _____ each day or within 7 days for a batching of verbal orders. The plan is to_____.
5. If unable to reach a clinic provider and a verbal order or consultation is needed, the PHN will call another provider (alternate for the site) and if unable to reach alternate provider will page Leslie Miller, MD (Pager # 206-995-1871).
6. Alternate provider for this site is: _____
7. The PHN will add the provider's name to the chart form and document the verbal order for EC.
8. The PHN will complete the plan portion of the EC chart form.
9. A two-week follow-up appointment will be made at: _____ Public Health – Seattle & King County Clinic.
10. Place large pharmacy label including lot # and expiration date on Plan B, small label on verbal order form and small label in service log.
11. If needed, Field PHN referrals to _____. If needed, DSHS SW referrals to _____.
12. The PHN will bring the paperwork within 14 days to _____ clinic and leave it: _____ _____for the provider's signature. If an off-site provider gave a verbal prescription then document the arrangements for obtaining a signature and chart review.
13. The paperwork will be submitted to the PHN clerk by: _____.
14. Self audit by PHN for practitioner's signature by: _____.

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Alonzo L. Plough, Ph.D., MPH, *Director*

Public Health—Seattle & King County
Guidelines for Standing Orders for a Medication or Treatment

1.0 PURPOSE

The purpose of the "Guidelines for Standing Orders for a Medication or Treatment" is to ensure that standing orders are developed and implemented in accordance with relevant Washington State Laws, scope of practice of staff, and community standards of practice.

2.0 REFERENCES

2.1 The law relating to the Practice of Medicine RCW 18.71.

2.2 The law relating to Nursing Care RCW 18.79.

2.3 The law relating to Pharmacists RCW 18.64.

2.4 The law relating to Legend Drugs—Prescription Drugs RCW 69.41.

3.0 DEFINITIONS

3.1 Standing Order: A standing order is a protocol or guideline for administering specific medications or treatments to a patient without consulting an authorized prescriber for a particular patient. The protocol/guideline includes 1) indications and contraindications for the treatment or medication; 2) relevant clinical assessment information that needs to be obtained in order to determine if administration of the medication or treatment is appropriate; 3) a specific order with a description of who has the authority to implement the order; 4) the physician signature authorizing the order and approval by other involved disciplines.

3.2 Administer: To administer means the direct application of a legend drug whether by injection, inhalation, ingestion, or other means, to the body of a patient or research subject.

3.3 Dispense: Dispense means the interpretation of a prescription or order for a legend drug and, pursuant to that prescription or order, the proper selection, measuring, compounding, labeling, or packaging necessary to prepare that prescription or order for delivery. Practitioners with prescriptive authority such as Physicians, Dentists, and Advanced Registered Nurse Practitioners with prescriptive authority are authorized to dispense the drugs which they prescribe.

They may **not** delegate this function to a nurse or other staff member. In addition, in a group practice, one practitioner may **not** be designated to dispense the drugs for all of the practitioners. This is considered to be the practice of pharmacy and may only be done by a pharmacist. If a practitioner dispenses, he/she needs to be aware of labeling and record keeping requirements that include placing at least the following information on the label: name of prescriber, name of patient, complete directions for use, name of the drug (brand or generic), strength of drug per dose, date of dispensing. The name and strength of the drug may be omitted if the practitioner determines that the patient should not have this information.

3.4 Dispensing Oral Contraceptives: A family planning clinic under contract with the Department of Social and Health Services may dispense commercially pre-packaged oral contraceptives upon the prescription of a licensed health care practitioner authorized to prescribe oral contraceptives. See RCW 69.41.030.

4.0 POLICY

4.1 Standing orders for medications or treatments will be implemented under the direction and signature of a licensed physician.

4.2 Specific protocols and guidelines for standing orders for medications and treatments will be reviewed and approved by the Professional Practice Committee prior to implementation.

4.3 Guidelines and protocols for standing orders must include:

4.3.1 Indications and contraindications for the treatment or medication.

4.3.2 Relevant medical history and physical assessment information that needs to be obtained in order to determine if administration of the medication or treatment is appropriate.

4.3.3 A specific order with a description of who has the authority to implement the order.

4.3.4 The physician signature authorizing the order and approval by other involved disciplines.

4.3.5 A plan for training and quality assurance.

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

HIV Drug Resistance Testing

INFORMATION FOR CLIENTS

People testing positive for HIV for the first time may get a free HIV drug resistance test. If you were diagnosed with HIV infection a long time ago, or if there is not enough blood leftover after your HIV test, or if you have very little virus in your blood, you may not receive a resistance test.

This information sheet will help answer your questions about HIV drug resistance testing.

What is HIV drug resistance?
Sometimes when a person takes medicine or drugs prescribed by a doctor for HIV, the HIV virus can change to become resistant to those medicines. If this happens, the medicines may not work as well to treat that virus. This HIV virus is said to be resistant.

How do we know if HIV is resistant?
Doctors have two different types of blood tests to look for drug resistance in HIV. These tests are done at special laboratories looking for resistance. Doctors use these tests in HIV clinics to help pick the right medicines for fighting off the type of HIV in a person's blood.

How can a person be infected with resistant HIV before taking HIV medicines?
If the person who gave you HIV had HIV drug resistance, that resistance can be passed to you.

How is the test done?
The test is done on the same blood you give for your HIV test. We put a code number (not your name or medical chart number) and send some of the leftover blood to a special laboratory to test for resistance.

Why is it important to do resistance testing on the blood from your HIV test?
We are testing the same blood used for your HIV test. The test happens as soon as you test positive for HIV so your doctor can know your results in a few weeks. Your doctor can use the test results to pick the best drugs to treat your HIV.

Most people do not have a resistant form of HIV when they first find out they have HIV so doctors rarely order the test for new HIV patients. Another reason is that these tests cost a lot of money (as much as $1,200 dollars). Resistance testing provided free by Public Health can allow doctors to have your results in a few weeks. If you are a person with a resistant type of HIV and your doctor waited to do the test, it might not show the resistance. You could have a resistant type of HIV and not know that some drugs may not work very well.

Doing the test close to the time you got HIV has the best chance of finding your resistant type of HIV. This means you may need different kinds of medicines. The fastest way to know is to test the blood from your HIV test.

How can you get the HIV resistance results?
The test results are hard to understand and best given to you by your doctor. Your medical provider or HIV counselor can tell you how to send them to the doctor you choose. You may need to sign an authorization form to tell us which doctor to send the test results to.

If you do not have a doctor, your counselor or the ACAP staff (206-284-9277) can help you find one. Your doctor will tell you what the test says about your HIV. If you want to wait to go to a doctor you can call your counselor or the clinic when you find one and your counselor will help you get all your HIV information to your doctor.

When can your doctor get the results of the HIV resistance test?
The test results can be sent your doctor, if known, in about 3 to 4 weeks.

If your HIV is resistant to drugs does that mean you would not be helped by HIV medicines?
There are lots of medicines to treat HIV. Sometimes HIV drugs do not work as well on resistant HIV, but they may still work. If your HIV is resistant, your doctor can use the test to help pick other drugs that will work.

Will anyone know about you or your HIV tests?
Washington State law makes everyone working with your HIV testing and health care keep it a secret. This secrecy or confidentiality means no one is allowed to talk about you or give information out about you unless you ask for your health information to be sent to your doctor. There are strong penalties for anyone breaking the confidentiality laws.

Is there any risk for you in this project?
If you have a resistant form of HIV you may worry more about your health. There is a very small and unlikely chance that your test results may become known to someone outside of the project staff. If that happens there are very big legal penalties. Every effort will be made to keep your test results private.

How can you benefit from this project?
The results will help your doctor choose the best medicines to treat your type of HIV. This should help you feel better and stay healthier.

Also, you will help other people. The results of resistance testing will help us learn what types of HIV are spreading in the Seattle area and which medicines might be best for people here. The tests will also help us decide if we can use blood from HIV tests to give resistance tests to more people in our state who are newly diagnosed with HIV.

What are your rights?
You do not have to tell us the name of a health care provider to receive your HIV test results either now or later. You can still take part in the counseling sessions and any other services offered here. This copy of the information sheet is yours to keep.

Who you can call if you have questions or concerns?
You may ask any questions about HIV testing including resistance testing at any time now or in the future. The project phone line is (206) 205-1470. You can call us to find out how to get your resistance results. Your doctor (or other health care provider) is the best person to answer your questions about treatment for HIV.

You may also call Susan Buskin, PhD, MPH – ARVDRT Project Principal Investigator (206) 205-6123

HIV (AIDS VIRUS) TEST INFORMATION

Public Health – Seattle & King County

HIV stands for Human Immunodeficiency Virus. It is the virus that causes AIDS (Acquired Immunodeficiency Syndrome). All people infected with HIV can spread HIV to others by having unprotected sex, sharing needles and injection equipment, and/or donating blood or organs. Infected mothers can spread HIV to their babies. HIV testing is voluntary and can be life-saving. This sheet describes HIV testing. It can help you decide whether or not to be tested.

How We Test for HIV; What the Tests Mean

We first perform a test for HIV antibodies. Antibodies are the body's response to the virus. We may also test for the virus in your blood using a process that can find HIV sooner than the antibody test. This result may take 2 or more weeks to return. Positive test results are confirmed by further tests.

A CONFIRMED POSITIVE test means that a person is infected with HIV and can infect others. For a confirmed positive test, we may further test to see if the virus is resistant to medicines commonly used to treat HIV infection.

A NEGATIVE test means there is no evidence of HIV infection. This usually means that the person does not have HIV. However, sometimes the infection may be too recent for the test to be positive. The current tests usually turn positive within one month of infection, sometimes longer. Therefore, if you were infected very recently, a negative test result could be wrong.

False results include negative tests in people who are infected and positive tests in people who are not infected. Indeterminate results are tests that are not clearly positive or negative. False and indeterminate tests are rare. They can be cleared up by more tests.

Benefits of Being Tested

There are important benefits to being tested and knowing your results. Many people with HIV will benefit from medicines that prevent AIDS and other illnesses. Tests can help to decide the best treatments to use. Also, test results can help people make choices about birth control and pregnancy. Although everyone should follow safer sex guidelines, many people find that knowing

their test results helps them to protect their partners and themselves. Some people want to know their test results before starting a new sexual relationship or becoming pregnant. Most people will feel better by learning that they do not have HIV.

Risks and Disadvantages of Being Tested

Some people may feel stressed or depressed before, during or after HIV testing. This is especially true when there is a positive result. Some people with negative tests may continue or increase their risks for HIV infection. They may worry less about having unprotected sex or sharing needles and/or injection equipment – and then get infected. Some people are afraid that their test results will get into the wrong hands, leading to discrimination. You should think about your support, including family and friends, and your insurance needs before you are tested.

Privacy and Confidentiality

Washington State law requires care providers and laboratories to report the names of HIV-infected persons to the local health department for disease monitoring. Names are not kept beyond 90 days after completion of the report. The confidentiality of HIV testing records is strongly protected by law. Penalties for violations of the law are severe.

Getting Test Results & Notifying Partners

In some cases, you may be able to get your result by phone. If your result is positive, you will be asked to return for in-person assistance. If you test positive and do not call or return for the result, we will try to contact you to tell you the result and provide assistance. If your test is positive, people with whom you have had sex or shared needles or other injection equipment need to be told that they should be tested for HIV. If you do not want to or cannot inform your partner(s), we can tell them for you without sharing your name.

Your HIV test and personal information may be used for disease and risk monitoring and research. We sometimes store blood samples to check the quality of our lab methods.

HIV Counseling Checklist

(PHSKC - This information is not released without a 9-part consent, unless otherwise permitted by State law.)

Pretest Date: _____

Reason for Testing: _____

_____

Risk Assessment: (See Patient Self Assessment Form) ❑ Low ❑ Moderate ❑ High

Sites: ❑ Oral ❑ Vaginal ❑ Anal / Insertive ❑ Anal / Receptive

Suicide Risk: (stated) ❑ Yes ❑ No ❑ Not evident by behavior

Stated symptom: (circle) Cough, Weight loss, Nodes, Lumps, Sores, Fatigue, Diarrhea, None

Test:

❑ Negative result: ❑ Positive result ❑ Indeterminate result
❑ Antibody test ❑ Window period

❑ Expected result: ❑ If negative, behavioral change
❑ If positive, partner notification
❑ Coping skills/Support

Patient Education:

❑ Abstinence	❑ Monogamy	❑ Decrease # of sex partners
❑ Latex condoms	❑ No IVDU	❑ Water based lubricant
❑ Bleach needles	❑ Birth control	❑ Avoid alcohol/drugs
❑ Benefits/risk of testing	❑ Insurance	❑ Needle Exchange Program

Notes: _____

_____

_____

Results to be given by: ❑ Phone ❑ Form ❑ Appointment

Signature _____

Posttest Date: _____

HIV Post Test Counseling Checklist (See Counseling Guidelines)

Negative: meaning of test, risk reduction, lack of immunity

❑ Phone ❑ Handout/Form ❑ In person

Positive:

❑ Risk of transmission to others ❑ Resources, APU, NWFC, _____
❑ Benefits of early medical care
Partner notification: ❑ By patient ❑ Needs assistance ❑ CDI/APU

Indeterminate: ❑ Lab information Sheet ❑ Retesting/When _____

Notes: _____

_____

_____

Signature _____

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Place Patient Information Sticker Here
OR Name & DOB

rev: 09.01.05

HIV Test Risk Assessment Form

Please answer these questions. Your answers will help us understand your risk for catching HIV (the virus that causes AIDS). All of your answers are kept private. **If a question is unclear, please circle the number and the staff will help you answer the question.** (*This information is not released without a 9-part consent, unless otherwise permitted by State law.)

1. Your age _____ Sex: ❑ Male ❑ Female

2. Why do you want to take an HIV test? _____
   _____
   _____

3. Have you ever been tested for HIV? ❑ Yes ❑ No
   If Yes, when was your last test? Month _____ Year _____

   What was the result? ❑ Positive ❑ Negative ❑ Unknown

4. Between 1977 and 1985, did you have any blood transfusions or receive other blood products? ❑ Yes ❑ No

5. Since 1977, have you ever:
   a) Been accidentally stuck with a bloody needle? ❑ Yes ❑ No
   b) Had blood from another person on your skin? ❑ Yes ❑ No

6. About how often do you drink alcohol or use other drugs?

   ❑ Once a day ❑ Once a week ❑ Once a month ❑ Less than once a month

7. Have you ever used street/recreational drugs? ❑ Yes ❑ No
   If Yes, which ones? _____

8. Have you ever used needles to shoot street drugs? ❑ Yes ❑ No
   If Yes, when was the last time? Month _____ Year _____

9. Since 1977, have you ever had **sex** or **shared needles** with any of the following people:

   a) A person who has the HIV virus? ❑ Yes ❑ No
   b) A man who has had male sex partners? ❑ Yes ❑ No
   c) A person who used needles to shoot street drugs? ❑ Yes ❑ No

10. Have you ever had sex with more than 4 different partners during the same year? ❑ Yes ❑ No
    If Yes, what year was that? Year _____

11. Have you ever traded sex for money or drugs? ❑ Yes ❑ No

12. During the past year, how many of your sex partners were male and how many were female?

    # Males _____ # Females _____

13. Have you ever had:
    a) A sexually transmitted disease? ❑ Yes ❑ No
    b) Hepatitis B ❑ Yes ❑ No
    c) A positive TB test or active TB? ❑ Yes ❑ No

14. When was the last time you had unprotected sex?
    ("Unprotected" means sex **without** using a latex condom or dental dam)

    Month _____ Year _____

15. Can you think of any other ways you may have been exposed HIV that were not mentioned above? ❑ Yes ❑ No
    If Yes, please specify:_____

    _____

    _____

16. If you are female, are you pregnant? ❑ Don't know ❑ Yes ❑ No

17. Are you choosing to have the test performed without using your name, will this test be anonymous? ❑ Yes ❑ No

18. Have you been vaccinated against Hepatitis B? ❑ Yes ❑ No ❑ Unknown

Reviewed by: _____ _____
Name / Signature Date

Notes:_____

_____

_____

_____

_____

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Place Patient Information Sticker Here
OR Name & DOB

Rev: 9.1.05

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Last Updated: 10-31-01

HIV (AIDS) TEST REPORT

_____ was tested on _____ for the HIV antibody (AIDS).

Provider: _____

Public Health - Seattle & King County

- ❑ **Auburn Public Health Center (206) 296-8400**
  20 Auburn Ave., Auburn, WA 98002
- ❑ **Columbia Public Health Center (206) 296-4650**
  4400-37th Ave. So., Seattle, WA 98118
- ❑ **Downtown Public Health Center (206) 296-4755**
  2124-4th Ave., Seattle, WA 98121
- ❑ **Eastgate Public Health Center (206) 296-4920**
  14350 S.E. Eastgate Way, Bellevue, WA 98007
- ❑ **Federal Way Public Health Center (206) 296-8410**
  33431 13th Place So., Federal Way, WA 98003
- ❑ **Kent Public Health Center (206) 296-4500**
  1404 S. Central Ave. Suite #112, Kent, WA 98032
- ❑ **Kent Teen Clinic (206) 296-7450**
  613 W. Gowe, Kent, WA 98032
- ❑ **North Public Health Center (206) 296-4765**
  10501 Meridian Ave. North, Seattle, WA 98133
- ❑ **Northshore Public Health Center (206) 296-9787**
  10808 N.E. 145th Street, Bothell, WA 98011
- ❑ **Renton Public Health Center (206) 296-4700**
  3001 N.E. 4th, Renton, WA 98056
- ❑ **White Center Public Health Center (206) 296-4620**
  10821-8th Ave. S.W., Seattle, WA 98146

Historial de Pruebas de VIH

Gracias por llenar este cuestionario. Recuerde que todas las respuestas que nos da se van a mantener privadas. Por favor lea todas las preguntas con cuidado. Las primeras preguntas son sobre sus pruebas de VIH pasadas.

1. Fecha de hoy __ __/ __ __ / __ __ __ __ (mes/día/año)

Sólo uso administrativo
2. ___/___/___ Fecha de la prueba

3. ¿En qué fecha (mes/ año) recibió por primera vez un resultado **positivo** para la prueba de VIH? [Nos gustaría saber en qué fecha le sacaron la sangre que dió el primer resultado positivo para el VIH. Haremos referencia a esta fecha en el cuestionario.]

___ ___ **/**___ ___ ___ ___ (mes/año)

Sólo uso administrativo
___/___/___ Fecha de la prueba

4. ¿Se hizo la prueba de manera anónima la primera vez que obtuvo un resultado positivo para el VIH? (en la fecha en pregunta 3) [Esto quiere decir que no dio su nombre para hacerse la prueba.]

☐$_1$ Sí ☐$_0$ No ☐$_7$ Prefiero no contestar ☐$_9$ No sé

5. ¿Cuál es el nombre del lugar donde recibió su primer resultado positivo a la prueba del VIH (en la fecha en pregunta 3)? Por ejemplo, puede ser el nombre de la clínica de salud en la comunidad, banco/laboratorio de sangre, oficina de médico privado, clínica de enfermedades de transmisión sexual.

Nombre del sitio: _____ Estado: _____

Sólo uso administrativo
_____ Código del tipo de sitio

6. ¿Porqué se hizo la prueba de VIH en la fecha en pregunta #3? ¿Cuál fue la razón?

[1] Porque usted cree o le preocupa que se haya expuesto al VIH en los últimos seis meses	☐$_0$ No	☐$_1$ Sí
[2] Porque usted se hace pruebas cada cierto tiempo y ya le tocaba hacerse la prueba otra vez	☐$_0$ No	☐$_1$ Sí
[3] Porque quiso asegurarse de que es VIH negativo	☐$_0$ No	☐$_1$ Sí
[4] Porque era requisito de una compañía de seguros, del ejército, una orden de la corte, o de alguna otra agencia o compañía	☐$_0$ No	☐$_1$ Sí
[5] Porque existe otra razón. Si la respuesta es sí, por favor escriba la razón _____	☐$_0$ No	☐$_1$ Sí

7. ¿Cuándo fue la **primera** vez que se hizo la prueba de VIH (en qué fecha le sacaron la sangre)? Si no está seguro/a, favor de estimar.

___ ___ / ___ ___ ___ ___ (mes/año)

8. ¿Ha recibido alguna vez un resultado **negativo** a la prueba VIH?

Sí ……☐1 ⟹ **Favor de pasar a pregunta 8a en la próxima página**

No……☐0
No sé……☐9 ⟹ **Favor de pasar a pregunta 9 en la próxima página**

8a. Antes del primer resultado positivo de la prueba de VIH (la fecha en pregunta 3), ¿cuándo fue la última vez que recibió un resultado negativo? (nos gustaría saber en que fecha le secaron la sangre)

___ ___ / ___ ___ ___ ___ (mes/año)

8b. ¿Cuál es el nombre del lugar donde recibió su último resultado **negativo** a la prueba de VIH (en la fecha en pregunta 8a)? Por ejemplo, puede ser el nombre de la clínica de salud, banco/laboratorio de sangre, oficina de médico privado, clínica de enfermedades de transmisión sexual.

Nombre del sitio: _____ Estado: _____

Sólo uso administrativo
_____ Código del tipo de sito

9. Cuántas veces se ha hecho la prueba VIH en los últimos dos años? Su primera prueba de VIH positiva actual esta incluida en esta cuenta.

_1_ (prueba positive actual) + ___ ___ (pruebas anteriores) = ☐☐

Las siguientes preguntas son sobre las medicinas para el VIH. A veces estos medicamentos se usan para prevenir la infección del VIH. Esto se conoce como profilaxis post-exposición, o PEP, por sus siglas en inglés. Algunos de estos medicamentos también se usan para el tratamiento de la Hepatitis B. Estos medicamentos también se pueden utilizar en tratamientos para el VIH que se conocen como HAART o "coctel Anti-SIDA". POR FAVOR, MIRE LAS FOTOS DE MEDICAMENTOS EN LA ÚLTIMA PÁGINA PARA CONSTESTAR LAS PROXIMAS PREGUNTAS.

10. En los últimos seis meses, anteriores al primer resultado **positivo** de la pregunta 3 ¿había tomado alguna de estas medicinas?

Sí ……☐1 ⟹ **Favor de pasar a pregunta 10a en la próxima página**

No……☐0
No sé……☐9 ⟹ **PARE, Ya terminó este cuestionario**

10a. ¿Cuáles ha tomado? Favor de hacer una lista (Si no está seguro/a del período de tiempo, por favor incluya medicinas que es POSIBLE que haya tomado durante los pasados seis meses?)

_____ _____

_____ _____

10b. En los seis meses anteriores al primer resultado **positivo** de la pregunta 3 ¿cuál fue el primer día en que tomó cualquiera de la medicinas que se muestran en las fotos? Si no está seguro/a, favor de estimar.

__ __/__ __/ __ __ __ __ (mes/día/año)

10c. ¿Está usted tomando ahora cualquiera de las medicinas que se muestran en las fotos?

Sí ……..☐1	⟹	**Favor de pasar a pregunta 10d en la próxima página**
No……...☐0 No sé……..☐9	} ⟹	**PARE, Ya terminó este cuestionario**

10d. ¿Cuál fue el último día en que tomó cualquiera de las medicinas que se muestran en las fotos? Si no está seguro/a, favor de estimar.

__ __/__ __/ __ __ __ __ (mes/día/año)

Muchas gracias por su participación y tiempo. Sus repuestas nos van a ayudar a entender mejor las pruebas de VIH.

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Instructions For Administering The HIV Incidence Questionnaire

The HIV Incidence Surveillance project is collecting HIV testing information from people who test HIV positive in King County. This data is needed to estimate HIV incidence and is part of case reporting.

At the next in person appointment please ask your client to complete the HIV Testing History Questionnaire. The questionnaire is designed to be self -administered but it may also be read to him or her.

After this please:

- Complete the information below.
- Send this form and the HIV testing questionnaire to us in the envelope provided. Or mail to Libby Page, Public Health –Seattle & King County, 400 Yesler Way, 3rd floor, Seattle WA 98101.

---

1. The name of your clinic _____
2. Medical record number_____
3. Date 1st positive HIV test ___/___/_____
4. Your initials _____
5. Today's date: ____/____/____

If you have any questions regarding this questionnaire or this program, please call incidence surveillance staff at (206) 205-1470.

Testing History Questionnaire

Thank you for filling out this form. Please read all questions carefully. Remember that all the answers you give will be kept private. First are a few questions about your past HIV tests.

1. Today's date

__ __/ __ __ / __ __ __ __
(MM/DD/YYYY)

Staff use only
2. ___/___/___
Ref test date

3. What was the month and year of the very first time you ever tested positive for HIV? List when you got your test, not when you got your results. We will refer to this test date again.

__ __/ __ __ __ __
(MM/YYYY)

4. When you first tested positive for HIV (on the date in question 3) were you given a number or a code to use to get your results instead of your name? (check one box).

Yes……☐ 1
No……☐ 0
I don't know……☐ 9
I don't want to answer…☐ 7

5. What was the name of the place where you got your first positive HIV test (on the date in question 3)? For example, this could be the name of a health clinic, blood bank, doctor's office, or STD clinic.

Site name: _____

State: _____

Staff use only
Site type code _____

6. Why did you get the HIV test on the date in question 3? Did you get that test: (please check yes or no **for each question**)

[1] Because you thought/were worried that you might have been exposed to HIV in the 6 months before (the date in question 3)?
Yes……☐ 1
No……☐ 0

[2] Because you get tested on a regular basis (for example, once a year or every six months), and it was time for you to get tested again?
Yes……☐ 1
No……☐ 0

[3] Because you were just checking to make sure you were HIV negative?
Yes……☐ 1
No……☐ 0

[4] Because it was required by either insurance, the military, the court, or by some other agency?
Yes……☐ 1
No……☐ 0

[5] Because there was some other reason you wanted to get tested?
If so, what is the reason?
Yes……☐ 1
No……☐ 0

Reason: _____

7. Did you ever have an HIV test before your first positive test?

Yes……☐ 1 → **GO TO QUESTION 7a**
No……☐ 0
I don't know……☐ 9
} **GO TO QUESTION 9**

7a. When was the very first time you ever got tested for HIV (when you got the test, not when you got the results)? Please make your best guess if you are not sure.

__ __/ __ __ __ __
(MM/YYYY)

8. Have you ever had an HIV test that was negative?

Yes……..☐$_1$ → **GO TO QUESTION 8a**

No……..☐$_0$

I don't know……..☐$_9$

GO TO QUESTION 9

8a. Before your first positive HIV test (as in question 3), when did you last test negative for HIV? List when you got the test, not when you got the results.

__ __/ __ __ __ __

(MM/YYYY)

8b. What was the name of the place where you had your last negative HIV test? For example, this could be the name of a health clinic, blood bank, doctor's office, or STD clinic.

Site name: _____

State: _____

Staff use only

Site type code _____

9. In the two years before your first positive test (on the date in question 3), how many times did you get tested for HIV? Your first positive test has been included for you in the count.

1 + ___ ___ = ☐☐

first positive test | **# of negative tests during prior 2 years** | **total # of tests in 2 years**

The last questions are about HIV medicines. Sometimes one or more of these is used to try to prevent HIV infection. This is called post-exposure prophylaxis, or PEP. Some of these medicines are also used to treat Hepatitis B. These medicines can also be used in HIV treatments called HAART or the AIDS cocktail. PLEASE USE THE PICTURES OF ANTI-RETROVIRAL MEDICINES ON THE LAST PAGE WHEN ANSWERING THE NEXT QUESTIONS

10. In the six months before your first positive HIV test (on the date in question 3), had you ever taken any antiretroviral medicines?

Yes……..☐$_1$ → **GO TO QUESTION 10a**

No……..☐$_0$

I don't know……..☐$_9$

STOP, you are finished

10a. Which ones did you take? Please list them. (If you are not sure of when you took the medicines, please include the ones you MIGHT have taken in the six months before your first positive test.)

Medicines: _____

_____

10b. What was the first day on which you took any of the medicines shown in the pictures? Please make your best guess if you are not sure.

__ __/ __ __ / __ __ __ __

(MM/DD/YYYY)

10c. Are you now taking any of the medicines shown in the pictures?

No……..☐$_0$ → **GO TO QUESTION 10d**

Yes……..☐$_1$

I don't know……..☐$_9$

STOP, you are finished

10d. When was the last day you took any of the medicines shown in the pictures? Please estimate if you are unsure.

__ __/ __ __ / __ __ __ __

(MM/DD/YYYY)

Thank you for your time today. Your answers will help us better understand HIV testing.

Staff use only

Data source: __ (1) Chart review
__ (2) Questionnaire: __ (1) self __ (2) interview __(9) unknown
__ (9) Unknown

New State Rules for HIV Testing

(effective June 18, 2005)

Robert W. Wood, MD, Director
HIV/AIDS Control Program
Public Health - Seattle & King Co.

Associate Professor of Medicine
University of Washington

What I'll Cover:

- Purposes of Washington State Administrative Code (WAC) changes
- New consenting procedure
- Simplified counseling rules
  - What to do if an HIV+ person does not return for results
- New partner notification rules make provider responsible unless referred to public health
- Who should now be tested for HIV?

Three Purposes of 2005 Rule Changes for HIV Testing :

- To increase the proportion of HIV+ persons who know their HIV status
- To facilitate more routine testing by primary care providers
- To increase the proportion of persons exposed to HIV who are informed of their exposure (partner notification)

Must the Patient Still Consent for HIV Testing?

- ***Yes***; but consent may now be verbal or written; (prior to these changes a separate consent was required)
- Patients must be explicitly told that HIV testing is recommended and agree to test
- Patient awareness of & consent for testing must be documented in the patient's record, such as:

  "I recommended HIV testing, and the patient agreed to test." ← **the new HIV test practice standard**

What Information Should be Provided to the Patient:*

- The benefits of learning HIV status and the potential dangers of HIV;
- The ways in which HIV is transmitted and ways to prevent transmission;
- The meaning of HIV test results and the importance of receiving HIV test results; and
- As appropriate, the availability of anonymous HIV testing and its differences from confidential testing. E.g., anonymous testing may not be appropriate in a person with signs or symptoms of HIV.

*** Unless the patient has been previously tested for HIV or declines this information**

What Changes in Rules Have Occurred in Consent & Counseling?

- Consent: Signing a separate consent is no longer required.
- Pre-test Counseling:
  - Can now be declined & shortened (e.g., for people previously tested).
  - Detailed & prescriptive rules for the content of pre-test counseling have been eliminated.
  - ***Client-centered counseling**** is now required & can better be adapted to patient needs. Client-centered counseling should:
    - » Be based on an assessment of the patient's risk
    - » Help the client set realistic behavior change goals to reduce risk of transmitting or acquiring HIV
    - » Create opportunities to build appropriate risk reduction skills
- Post-test Counseling MUST be provided if the patient tests HIV +
- Referral for counseling to other providers is encouraged, especially when the provider lacks time or counseling skills.

* See CDC's "Revised Guidelines for HIV Counseling; Nov. 2001

What if the Client Tests HIV+ but Fails to Return for Results?

- The provider should make every attempt to contact the client to provide test results & post-test counseling in person.
- If the provider is unsuccessful in making contact, the provider must provide patient identifying information to the local health officer who will attempt to ensure that the patient is aware of his/her HIV status and provider post-test counseling

Rule Changes re: Notification of Sexual and Needle-Sharing Partners

- Providers must **assure*** partner notification (PN) either by doing it themselves (in consultation with the local health dept.), or by **assuring*** referral to the local health dept.
- PN services must be provided in accord with HIV Partner Counseling & Referral Service Guidance^
- New rules permit local health officials to directly contact persons newly diagnosed with HIV after consultation with the health care provider.

*** Assurance requires follow-up**

^ See CDC PCRS Guidelines, December, 1998

Recommendations: Who Should Now Be Tested for HIV?

- Any person requesting pre-test counseling
- Persons at high risk for HIV, including:
  - » Sex & injection equipment sharing partners of persons with HIV
  - » Men who have had sex with men since 1975
    - Every 6 months; if unprotected anal sex with sero-discordant/unknown status partners, then every 3 months
  - » Injection drug users and their sex partners
  - » Persons with signs or symptoms of HIV or of immuno-suppression (e.g., thrush, recurrent yeast vaginitis)
  - » Persons who have had unprotected sex with multiple partners in the past year
  - » Persons diagnosed with another sexually transmitted disease
  - » Persons who had blood transfusions before 1985
- CDC says make HIV testing routine in groups where HIV prevalence is $\geq$ 1%

King County Risk Groups Infected:

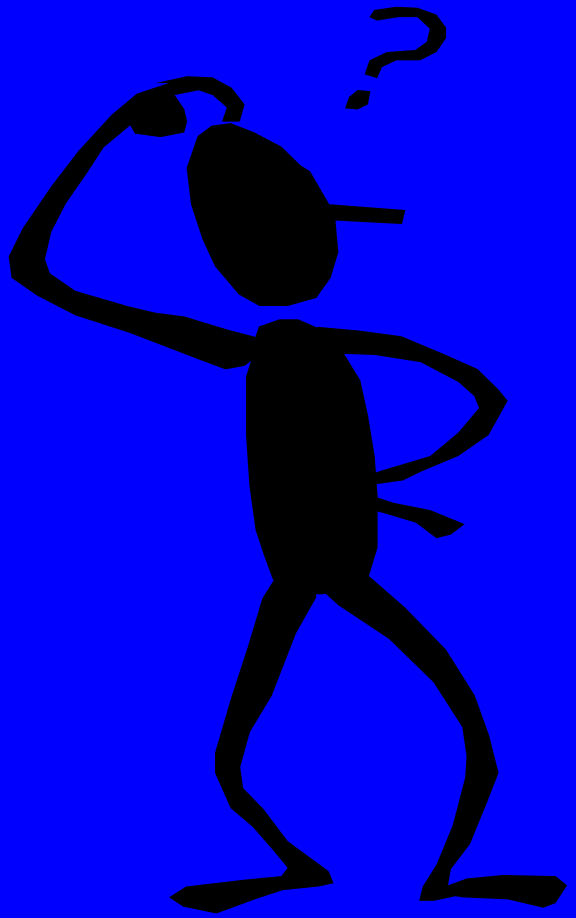
TARGET	Size of Population	% HIV +	Estimated # HIV+
MSM-IDU	~ 3,150	25%	790
MSM	~ 40,000	16%	6, 290
IDU	~ 15,000	4%	580
Heterosexual	~1,245,000	0.05%	640
Other	??	??	100
TOTAL:	1,737,034	0.5%	8,400*

* This estimate is **OLD**; updated estimates ~9,000 are coming

KC HIV infection rates, by location & sex, among the "sexually mature" (age 15+)

Population Segment:	Size of Population	% HIV +	Number HIV+
All King Co.	1,410,559	0.59%	8,350
Males	705,280	**1.08%**	7,605*
Females	705,280	0.11%	745
Just Seattle	489,275	**1.47%**	7,194
Males	244,638	**2.67%**	6,542*
Females	244,638	0.27%	652

*** At least 2 of 3 HIV+s males probably know they're infected**



Questions?

CONTRACEPTIVE IMPLANT SYSTEM **INSERTION** SKILLS DOCUMENTATION

The provider is to initial and date when each item is complete.

Provider Preparation

_____ Watched insertion video and practiced with plastic arm model.

_____ Read current Family Planning Contraceptive Implant Practice Guidelines.

_____ Completed observed training if required (no prior experience) and has inserted 2 or more implant systems with the Family Planning Medical Director or other training.

_____ Aware that any difficult insertion can be stopped and referred to the Family Planning Medical Director at the next visit.

Procedure Preparation

_____ Patient history taken and scrutinized for contraindications.

_____ Can list the absolute contraindications and relative contraindications to contraceptive implant.

_____ Screens for betadine, tape, and lidocaine with epinephrine allergies before insertion.

_____ Collects the appropriate information and performs the screening tests required prior to the insertion.

_____ Identifies women eligible for reduced funding and orders free kits when possible.

_____ Correctly counsels the client about the possible risks and side effects from the insertion procedure and use of the implant system including difficult removal and bleeding irregularities.

_____ Correctly identifies and uses the PHSKC Family Planning Program Contraceptive Implant Procedure Form, the Treatment Consent Form, and the BCM Specific Consent Form when appropriate.

_____ Labels the chart with the Lot number and Expiration number for the kit and applies a DO NOT PURGE orange sticker to the outside of the chart.

_____ Ascertains the clinic has the equipment and medications available for an anaphylactic or fainting reaction, or hemorrhage if it occurs.

Procedure

_____ Performs HCG test before the insertion and ascertains no risk of early undiagnosed pregnancy.

_____ Correctly positions the nondominant arm for insertion about 6 to 8 cm above elbow on the medial surface between the bicep or tricep muscles. Marks with the template the insertion tracks if Norplant system planned so client can see where implants to be inserted.

_____ Anesthetic with epinephrine infiltrated with needle correctly. Skin preparation done with antiseptic and sterile field/technique maintained with procedure. Scalpel incision (if needed) made to less than 2-4 mm in length. Implant(s) placed according to the manufacture's instructions. Implant(s) palpated to verify system is in place.

_____ Steri strips applied tightly and pressure dressing applied and client instructed to keep dressing on for 24 hours and steri strips for 5 days.

_____ Counsels the client about a backup method for 1 week if indicated.

_____ Supplies the client with a copy of the package insert (prior to insertion) and the PHSKC patient education handout . Client scheduled for a recheck in 2 to 4 weeks and client taught the correct warning signs of infection or expulsion and instructed to return if they occur.

Reviewed by Family Planning Medical Director_____ Date approved for independent insertion:_____

☐ Norplant ☐ Implanon ☐ Jadelle

I have read and completed the above and I agree I am ready for independent Contraceptive Implant insertion procedures.

Provider Signature_____ **Date**_____

CONTRACEPTIVE IMPLANT SYSTEM **REMOVAL** SKILLS DOCUMENTATION

The provider is to initial and date when each item is complete.

Provider Preparation

_____ Watched Implant removal video and practiced with plastic arm model.

_____ Read current Family Planning Contraceptive Implant practice guidelines.

_____Completed observed training if required (no prior experience) and has removed 2 or more Implant systems with the Family Planning Medical Director or other training documentation such as a letter reporting prior experience.

_____Aware that any difficult removal can be stopped and referred emergently to emergency room or scheduled for the Family Planning Medical Director's next visit.

_____ If history of a lost (not palpable), or broken implant, medical director consultation should be obtained prior to removal attempt.

Procedure Preparation

_____Reason for Implant removal reviewed. If reason is for irregular bleeding and less then 1 year of use it is strongly recommended a trial of NSAIDS or even OCPS be attempted to regulate bleeding and pregancy, cervicitis and/or endometritis ruled out.

_____ Patient history taken and the plans made for follow up birth control method.

_____ Screens for betadine, tape, and lidocaine with epinephrine allergies before removal.

_____Correctly counsels the client about the possible risks and side effects from the Implant removal procedure including injury to the arm, broken implants, infection, bruising, and the possible need for a second procedure to complete the removal.

_____Correctly identifies and uses the PHSKC Family Planning Program consent forms as appropriate.

_____ Ascertains the clinic has the equipment and medications available for an anaphylactic or vasovagal reaction, or hemorrhage if it occurs.

Procedure

_____ Anesthetic with epinephrine infiltrated with needle correctly. Skin preparation done with antiseptic and sterile field/technique maintained with the procedure . Scalpel incision made less than 2-6 mm in length, over the old scar.

_____ Uses the "pop out" method along with blunt dissection. Uses the norgrasp modified vasectomy tool clamp instrument.

_____ Counts, shows patient, and documents all implants removed.

_____ If a reinsertion planned used then proximal block is recommended for removal so less additional anesthetic usually needed.

_____ Steri strips applied tightly and pressure dressing applied and client instructed to keep dressing on for 24 hours and steri strips for 5 days.

_____ Counsels the client about the need for immediate contraception. Copy of the Implant Procedure Patient Education Handout supplied.

_____ Client scheduled for a recheck in 2 to 4 weeks and client taught the correct warning signs of wound infection and told of the need to return if they occur.

Reviewed by Family Planning Medical Director_____ Date approved for independent removal:_____

☐ Norplant ☐ Implanon ☐ Jadelle

I have read and completed the above and I agree I am ready for independent Contraceptive Implant removal procedures.

Provider Signature_____ **Date**_____

Depo-Provera Perpetual Calendar

4-TIMES-A-YEAR DOSING FLEXIBILITY

[based on 3-month (13-week) dosing intervals, with the flexibility of dosing between weeks 11 and 13]

GIVEN	DUE
Jan 1	Mar 19 - Apr 2
Jan 2	Mar 20 - Apr 3
Jan 3	Mar 21 - Apr 4
Jan 4	Mar 22 - Apr 5
Jan 5	Mar 23 - Apr 6
Jan 6	Mar 24 - Apr 7
Jan 7	Mar 25 - Apr 8
Jan 8	Mar 26 - Apr 9
Jan 9	Mar 27 - Apr 10
Jan 10	Mar 28 - Apr 11
Jan 11	Mar 29 - Apr 12
Jan 12	Mar 30 - Apr 13
Jan 13	Mar 31 - Apr 14
Jan 14	Apr 1 - Apr 15
Jan 15	Apr 2 - Apr 16
Jan 16	Apr 3 - Apr 17
Jan 17	Apr 4 - Apr 18
Jan 18	Apr 5 - Apr 19
Jan 19	Apr 6 - Apr 20
Jan 20	Apr 7 - Apr 21
Jan 21	Apr 8 - Apr 22
Jan 22	Apr 9 - Apr 23
Jan 23	Apr 10 - Apr 24
Jan 24	Apr 11 - Apr 25
Jan 25	Apr 12 - Apr 26
Jan 26	Apr 13 - Apr 27
Jan 27	Apr 14 - Apr 28
Jan 28	Apr 15 - Apr 29
Jan 29	Apr 16 - Apr 30
Jan 30	Apr 17 - May 1
Jan 31	Apr 18 - May 2
Feb 1	Apr 19 - May 3
Feb 2	Apr 20 - May 4
Feb 3	Apr 21 - May 5
Feb 4	Apr 22 - May 6
Feb 5	Apr 23 - May 7
Feb 6	Apr 24 - May 8
Feb 7	Apr 25 - May 9
Feb 8	Apr 26 - May 10
Feb 9	Apr 27 - May 11
Feb 10	Apr 28 - May 12
Feb 11	Apr 29 - May 13
Feb 12	Apr 30 - May 14
Feb 13	May 1 - May 15
Feb 14	May 2 - May 16
Feb 15	May 3 - May 17

GIVEN	DUE
Feb 16	May 4 - May 18
Feb 17	May 5 - May 19
Feb 18	May 6 - May 20
Feb 19	May 7 - May 21
Feb 20	May 8 - May 22
Feb 21	May 9 - May 23
Feb 22	May 10 - May 24
Feb 23	May 11 - May 25
Feb 24	May 12 - May 26
Feb 25	May 13 - May 27
Feb 26	May 14 - May 28
Feb 27	May 15 - May 29
Feb 28	May 16 - May 30
Mar 1	May 17 - May 31
Mar 2	May 18 - Jun 1
Mar 3	May 19 - Jun 2
Mar 4	May 20 - Jun 3
Mar 5	May 21 - Jun 4
Mar 6	May 22 - Jun 5
Mar 7	May 23 - Jun 6
Mar 8	May 24 - Jun 7
Mar 9	May 25 - Jun 8
Mar 10	May 26 - Jun 9
Mar 11	May 27 - Jun 10
Mar 12	May 28 - Jun 11
Mar 13	May 29 - Jun 12
Mar 14	May 30 - Jun 13
Mar 15	May 31 - Jun 14
Mar 16	Jun 1 - Jun 15
Mar 17	Jun 2 - Jun 16
Mar 18	Jun 3 - Jun 17
Mar 19	Jun 4 - Jun 18
Mar 20	Jun 5 - Jun 19
Mar 21	Jun 6 - Jun 20
Mar 22	Jun 7 - Jun 21
Mar 23	Jun 8 - Jun 22
Mar 24	Jun 9 - Jun 23
Mar 25	Jun 10 - Jun 24
Mar 26	Jun 11 - Jun 25
Mar 27	Jun 12 - Jun 26
Mar 28	Jun 13 - Jun 27
Mar 29	Jun 14 - Jun 28
Mar 30	Jun 15 - Jun 29
Mar 31	Jun 16 - Jun 30
Apr 1	Jun 17 - Jul 1
Apr 2	Jun 18 - Jul 2

GIVEN	DUE
Apr 3	Jun 19 - Jul 3
Apr 4	Jun 20 - Jul 4
Apr 5	Jun 21 - Jul 5
Apr 6	Jun 22 - Jul 6
Apr 7	Jun 23 - Jul 7
Apr 8	Jun 24 - Jul 8
Apr 9	Jun 25 - Jul 9
Apr 10	Jun 26 - Jul 10
Apr 11	Jun 27 - Jul 11
Apr 12	Jun 28 - Jul 12
Apr 13	Jun 29 - Jul 13
Apr 14	Jun 30 - Jul 14
Apr 15	Jul 1 - Jul 15
Apr 16	Jul 2 - Jul 16
Apr 17	Jul 3 - Jul 17
Apr 18	Jul 4 - Jul 18
Apr 19	Jul 5 - Jul 19
Apr 20	Jul 6 - Jul 20
Apr 21	Jul 7 - Jul 21
Apr 22	Jul 8 - Jul 22
Apr 23	Jul 9 - Jul 23
Apr 24	Jul 10 - Jul 24
Apr 25	Jul 11 - Jul 25
Apr 26	Jul 12 - Jul 26
Apr 27	Jul 13 - Jul 27
Apr 28	Jul 14 - Jul 28
Apr 29	Jul 15 - Jul 29
Apr 30	Jul 16 - Jul 30
May 1	Jul 17 - Jul 31
May 2	Jul 18 - Aug 1
May 3	Jul 19 - Aug 2
May 4	Jul 20 - Aug 3
May 5	Jul 21 - Aug 4
May 6	Jul 22 - Aug 5
May 7	Jul 23 - Aug 6
May 8	Jul 24 - Aug 7
May 9	Jul 25 - Aug 8
May 10	Jul 26 - Aug 9
May 11	Jul 27 - Aug 10
May 12	Jul 28 - Aug 11
May 13	Jul 29 - Aug 12
May 14	Jul 30 - Aug 13
May 15	Jul 31 - Aug 14
May 16	Aug 1 - Aug 15
May 17	Aug 2 - Aug 16
May 18	Aug 3 - Aug 17

GIVEN	DUE
May 19	Aug 4 - Aug 18
May 20	Aug 5 - Aug 19
May 21	Aug 6 - Aug 20
May 22	Aug 7 - Aug 21
May 23	Aug 8 - Aug 22
May 24	Aug 9 - Aug 23
May 25	Aug 10 - Aug 24
May 26	Aug 11 - Aug 25
May 27	Aug 12 - Aug 26
May 28	Aug 13 - Aug 27
May 29	Aug 14 - Aug 28
May 30	Aug 15 - Aug 29
May 31	Aug 16 - Aug 30
Jun 1	Aug 17 - Aug 31
Jun 2	Aug 18 - Sept 1
Jun 3	Aug 19 - Sept 2
Jun 4	Aug 20 - Sept 3
Jun 5	Aug 21 - Sept 4
Jun 6	Aug 22 - Sept 5
Jun 7	Aug 23 - Sept 6
Jun 8	Aug 24 - Sept 7
Jun 9	Aug 25 - Sept 8
Jun 10	Aug 26 - Sept 9
Jun 11	Aug 27 - Sept 10
Jun 12	Aug 28 - Sept 11
Jun 13	Aug 29 - Sept 12
Jun 14	Aug 30 - Sept 13
Jun 15	Aug 31 - Sept 14
Jun 16	Sept 1 - Sept 15
Jun 17	Sept 2 - Sept 16
Jun 18	Sept 3 - Sept 17
Jun 19	Sept 4 - Sept 18
Jun 20	Sept 5 - Sept 19
Jun 21	Sept 6 - Sept 20
Jun 22	Sept 7 - Sept 21
Jun 23	Sept 8 - Sept 22
Jun 24	Sept 9 - Sept 23
Jun 25	Sept 10 - Sept 24
Jun 26	Sept 11 - Sept 25
Jun 27	Sept 12 - Sept 26
Jun 28	Sept 13 - Sept 27
Jun 29	Sept 14 - Sept 28
Jun 30	Sept 15 - Sept 29
Jul 1	Sept 16 - Sept 30
Jul 2	Sept 17 - Oct 1
Jul 3	Sept 18 - Oct 2

Long-acting, Reversible

Depo-Provera®
Contraceptive Injection
medroxyprogesterone acetate injectable suspension

4 Times a Year

Depo-Provera Perpetual Calendar

4-TIMES-A-YEAR DOSING FLEXIBILITY

[based on 3-month (13-week) dosing intervals, with the flexibility of dosing between weeks 11 and 13]

GIVEN	DUE
Jul 4	Sept 19 - Oct 3
Jul 5	Sept 20 - Oct 4
Jul 6	Sept 21 - Oct 5
Jul 7	Sept 22 - Oct 6
Jul 8	Sept 23 - Oct 7
Jul 9	Sept 24 - Oct 8
Jul 10	Sept 25 - Oct 9
Jul 11	Sept 26 - Oct 10
Jul 12	Sept 27 - Oct 11
Jul 13	Sept 28 - Oct 12
Jul 14	Sept 29 - Oct 13
Jul 15	Sept 30 - Oct 14
Jul 16	Oct 1 - Oct 15
Jul 17	Oct 2 - Oct 16
Jul 18	Oct 3 - Oct 17
Jul 19	Oct 4 - Oct 18
Jul 20	Oct 5 - Oct 19
Jul 21	Oct 6 - Oct 20
Jul 22	Oct 7 - Oct 21
Jul 23	Oct 8 - Oct 22
Jul 24	Oct 9 - Oct 23
Jul 25	Oct 10 - Oct 24
Jul 26	Oct 11 - Oct 25
Jul 27	Oct 12 - Oct 26
Jul 28	Oct 13 - Oct 27
Jul 29	Oct 14 - Oct 28
Jul 30	Oct 15 - Oct 29
Jul 31	Oct 16 - Oct 30
Aug 1	Oct 17 - Oct 31
Aug 2	Oct 18 - Nov 1
Aug 3	Oct 19 - Nov 2
Aug 4	Oct 20 - Nov 3
Aug 5	Oct 21 - Nov 4
Aug 6	Oct 22 - Nov 5
Aug 7	Oct 23 - Nov 6
Aug 8	Oct 24 - Nov 7
Aug 9	Oct 25 - Nov 8
Aug 10	Oct 26 - Nov 9
Aug 11	Oct 27 - Nov 10
Aug 12	Oct 28 - Nov 11
Aug 13	Oct 29 - Nov 12
Aug 14	Oct 30 - Nov 13
Aug 15	Oct 31 - Nov 14
Aug 16	Nov 1 - Nov 15
Aug 17	Nov 2 - Nov 16
Aug 18	Nov 3 - Nov 17

GIVEN	DUE
Aug 19	Nov 4 - Nov 18
Aug 20	Nov 5 - Nov 19
Aug 21	Nov 6 - Nov 20
Aug 22	Nov 7 - Nov 21
Aug 23	Nov 8 - Nov 22
Aug 24	Nov 9 - Nov 23
Aug 25	Nov 10 - Nov 24
Aug 26	Nov 11 - Nov 25
Aug 27	Nov 12 - Nov 26
Aug 28	Nov 13 - Nov 27
Aug 29	Nov 14 - Nov 28
Aug 30	Nov 15 - Nov 29
Aug 31	Nov 16 - Nov 30
Sept 1	Nov 17 - Dec 1
Sept 2	Nov 18 - Dec 2
Sept 3	Nov 19 - Dec 3
Sept 4	Nov 20 - Dec 4
Sept 5	Nov 21 - Dec 5
Sept 6	Nov 22 - Dec 6
Sept 7	Nov 23 - Dec 7
Sept 8	Nov 24 - Dec 8
Sept 9	Nov 25 - Dec 9
Sept 10	Nov 26 - Dec 10
Sept 11	Nov 27 - Dec 11
Sept 12	Nov 28 - Dec 12
Sept 13	Nov 29 - Dec 13
Sept 14	Nov 30 - Dec 14
Sept 15	Dec 1 - Dec 15
Sept 16	Dec 2 - Dec 16
Sept 17	Dec 3 - Dec 17
Sept 18	Dec 4 - Dec 18
Sept 19	Dec 5 - Dec 19
Sept 20	Dec 6 - Dec 20
Sept 21	Dec 7 - Dec 21
Sept 22	Dec 8 - Dec 22
Sept 23	Dec 9 - Dec 23
Sept 24	Dec 10 - Dec 24
Sept 25	Dec 11 - Dec 25
Sept 26	Dec 12 - Dec 26
Sept 27	Dec 13 - Dec 27
Sept 28	Dec 14 - Dec 28
Sept 29	Dec 15 - Dec 29
Sept 30	Dec 16 - Dec 30
Oct 1	Dec 17 - Dec 31
Oct 2	Dec 18 - Jan 1
Oct 3	Dec 19 - Jan 2

GIVEN	DUE
Oct 4	Dec 20 - Jan 3
Oct 5	Dec 21 - Jan 4
Oct 6	Dec 22 - Jan 5
Oct 7	Dec 23 - Jan 6
Oct 8	Dec 24 - Jan 7
Oct 9	Dec 25 - Jan 8
Oct 10	Dec 26 - Jan 9
Oct 11	Dec 27 - Jan 10
Oct 12	Dec 28 - Jan 11
Oct 13	Dec 29 - Jan 12
Oct 14	Dec 30 - Jan 13
Oct 15	Dec 31 - Jan 14
Oct 16	Jan 1 - Jan 15
Oct 17	Jan 2 - Jan 16
Oct 18	Jan 3 - Jan 17
Oct 19	Jan 4 - Jan 18
Oct 20	Jan 5 - Jan 19
Oct 21	Jan 6 - Jan 20
Oct 22	Jan 7 - Jan 21
Oct 23	Jan 8 - Jan 22
Oct 24	Jan 9 - Jan 23
Oct 25	Jan 10 - Jan 24
Oct 26	Jan 11 - Jan 25
Oct 27	Jan 12 - Jan 26
Oct 28	Jan 13 - Jan 27
Oct 29	Jan 14 - Jan 28
Oct 30	Jan 15 - Jan 29
Oct 31	Jan 16 - Jan 30
Nov 1	Jan 17 - Jan 31
Nov 2	Jan 18 - Feb 1
Nov 3	Jan 19 - Feb 2
Nov 4	Jan 20 - Feb 3
Nov 5	Jan 21 - Feb 4
Nov 6	Jan 22 - Feb 5
Nov 7	Jan 23 - Feb 6
Nov 8	Jan 24 - Feb 7
Nov 9	Jan 25 - Feb 8
Nov 10	Jan 26 - Feb 9
Nov 11	Jan 27 - Feb 10
Nov 12	Jan 28 - Feb 11
Nov 13	Jan 29 - Feb 12
Nov 14	Jan 30 - Feb 13
Nov 15	Jan 31 - Feb 14
Nov 16	Feb 1 - Feb 15
Nov 17	Feb 2 - Feb 16
Nov 18	Feb 3 - Feb 17

GIVEN	DUE
Nov 19	Feb 4 - Feb 18
Nov 20	Feb 5 - Feb 19
Nov 21	Feb 6 - Feb 20
Nov 22	Feb 7 - Feb 21
Nov 23	Feb 8 - Feb 22
Nov 24	Feb 9 - Feb 23
Nov 25	Feb 10 - Feb 24
Nov 26	Feb 11 - Feb 25
Nov 27	Feb 12 - Feb 26
Nov 28	Feb 13 - Feb 27
Nov 29	Feb 14 - Feb 28
Nov 30	Feb 15 - Mar 1
Dec 1	Feb 16 - Mar 2
Dec 2	Feb 17 - Mar 3
Dec 3	Feb 18 - Mar 4
Dec 4	Feb 19 - Mar 5
Dec 5	Feb 20 - Mar 6
Dec 6	Feb 21 - Mar 7
Dec 7	Feb 22 - Mar 8
Dec 8	Feb 23 - Mar 9
Dec 9	Feb 24 - Mar 10
Dec 10	Feb 25 - Mar 11
Dec 11	Feb 26 - Mar 12
Dec 12	Feb 27 - Mar 13
Dec 13	Feb 28 - Mar 14
Dec 14	Mar 1 - Mar 15
Dec 15	Mar 2 - Mar 16
Dec 16	Mar 3 - Mar 17
Dec 17	Mar 4 - Mar 18
Dec 18	Mar 5 - Mar 19
Dec 19	Mar 6 - Mar 20
Dec 20	Mar 7 - Mar 21
Dec 21	Mar 8 - Mar 22
Dec 22	Mar 9 - Mar 23
Dec 23	Mar 10 - Mar 24
Dec 24	Mar 11 - Mar 25
Dec 25	Mar 12 - Mar 26
Dec 26	Mar 13 - Mar 27
Dec 27	Mar 14 - Mar 28
Dec 28	Mar 15 - Mar 29
Dec 29	Mar 16 - Mar 30
Dec 30	Mar 17 - Mar 31
Dec 31	Mar 18 - Apr 1

Contraindicated in patients with known or suspected pregnancy or with undiagnosed vaginal bleeding.

Long-acting, Reversible

Please see accompanying full prescribing information.

Depo-Provera®
Contraceptive Injection
medroxyprogesterone acetate injectable suspension

4 Times a Year

Pharmacia & Upjohn

USX 2712 February 1999

8379-12

Last updated 4/23/01

IUD INSERTION SKILLS DOCUMENTATION

The provider is to initial and date when each item is complete.

Provider Preparation

_____ Watched Ortho T380A and Berlex Lng IUS video and practiced with plastic hand held IUD model.

_____ Read current Family Planning IUD practice guidelines.

_____ Completed observed training if required (no prior experience) and has inserted 5 or more IUDs with the Family Planning Medical Director or other training. If experienced copper provider need 2 Lng IUS insertions to learn this technique.

_____ Aware that any difficult insertion can be stopped and refer to the Family Planning Medical Director.

_____ Any nulligravid patient must be inserted by a physician.

Procedure Preparation

_____ Patient history taken and scrutinized for contraindications.

_____ Can list the absolute contraindications to IUD insertion (copper or Lng IUS)

_____ Can list the relative contraindications to IUD insertion. (copper of Lng IUS)

_____ Screens for betadine, copper, lidocaine, silicone, polyethylene, and levonorgestrel allergies (as appropriate).

_____ Collects the appropriate information and performs the screening tests required prior to the IUD insertion.

_____ Correctly counsels the client about the possible risks and side effects from the IUD insertion procedure and use of the IUD.

_____ Correctly identifies and uses the PHSKC Family Planning Program **IUD Insertion Procedure Form**, the **Treatment Consent Form**, and the **Specific Birth Control Method Informed Consent Form** when appropriate. Use the **Implant/IUD Log** to record the insertion.

_____ Ascertains the clinic has the equipment and medications available for a vasovagal reaction or hemorrhage if it occurs.

Procedure

_____ Performs bimanual exam before the insertion and correctly identifies uterine position/cervical flexion.

_____ If desired by client infiltrates cervix with 1% lidocaine (without epinephrine), no more than 10 ml, with 25 G or smaller needle size to planned tenaculum site and if needed to paracervical locations.

_____ Places uterine tenaculum on appropriate cervical lip according to cervical flexion/fundus position.

_____ Sounds gently and if a lot of force is needed defers the insertion to the Medical Director.

_____ If the sound depth is beyond the 3 inch metal knob the provider must be able to feel comfortable that the uterine depth is still less than or equal to 9 cm so IUD insertion is still appropriate. Also verify uterine depth greater than or equal to 6 cm.

_____ Copious blood or severe pain with the sounding should cause the provider to consider a possible perforation and the IUD should probably not be placed that day. Consult the Family Planning Medical Director, observe the vital signs, and consider checking the hematocrit, if these are stable and the bleeding and pain resolve then the client can probably go home and return for the insertion in 2 weeks with the Family Planning Medical Director. NEVER insert the IUD if there is any concern about a possible perforation.

_____ Load the IUD arms and set the blue depth guard using the metal sound as a guide and never set or allow the blue guard to be greater than 9 to 10 cm so the total IUD insertion is kept at less than or 9 cm depth.

_____ Trim the strings to 2 to 3 inches. Be aware that the length of the total device plus the string as it is packaged is only 15 cm (T380A) or (T380A) or 19 inches (Lng IUS). This means when placing a T380A into a typical 8 cm uterus there should be string showing from os no less than approximately 7 cm after insertion (copper) or 15 inches (LNG IUS) if the IUD was correctly placed at the fundus.

_____ Knows to schedule the client for a recheck in 2 to 4 weeks and to teach the client the correct warning signs.

Reviewed by Family Planning Medical Director_____ Date approved for independent IUD insertion:_____

I have read and completed the above and I agree I am ready for independent IUD insertion. T380 ☐ **Lng IUS** ☐

Provider Signature_____ **Date**_____

U.S. Department of Health and Human Services

MEDWATCH

The FDA Safety Information and Adverse Event Reporting Program

For VOLUNTARY reporting of adverse events and product problems

Page ____ of ____

Form Approved: OMB No. 0910-0291 Expires: 04/30/03
See OMB statement on reverse

FDA Use Only

Triage unit sequence #

A. Patient information

1. **Patient identifier**
In confidence

2. **Age at time of event:**
or
Date of birth:

3. **Sex**
☐ female
☐ male

4. **Weight**
____ lbs
or
____ kgs

B. Adverse event or product problem

1. ☐ **Adverse event** and/or ☐ **Product problem** (e.g., defects/malfunctions)

2. **Outcomes attributed to adverse event** (check all that apply)
☐ death _____ (mo/day/yr)
☐ life-threatening
☐ hospitalization - initial or prolonged
☐ disability
☐ congenital anomaly
☐ required intervention to prevent permanent impairment/damage
☐ other: _____

3. **Date of event** (mo/day/yr)

4. **Date of this report** (mo/day/yr)

5. **Describe event or problem**

6. **Relevant tests/laboratory data,** including dates

7. **Other relevant history, including preexisting medical conditions** (e.g., allergies, race, pregnancy, smoking and alcohol use, hepatic/renal dysfunction, etc.)

C. Suspect medication(s)

1. **Name** (give labeled strength & mfr/labeler, if known)
#1
#2

2. **Dose, frequency & route used**
#1
#2

3. **Therapy dates** (if unknown, give duration) from/to (or best estimate)
#1
#2

4. **Diagnosis for use** (indication)
#1
#2

5. **Event abated after use stopped or dose reduced**
#1 ☐ yes ☐ no ☐ doesn't apply
#2 ☐ yes ☐ no ☐ doesn't apply

6. **Lot #** (if known)
#1
#2

7. **Exp. date** (if known)
#1
#2

8. **Event reappeared after reintroduction**
#1 ☐ yes ☐ no ☐ doesn't apply
#2 ☐ yes ☐ no ☐ doesn't apply

9. **NDC #** (for product problems only)
- -

10. **Concomitant medical products** and therapy dates (exclude treatment of event)

D. Suspect medical device

1. **Brand name**

2. **Type of device**

3. **Manufacturer name & address**

4. **Operator of device**
☐ health professional
☐ lay user/patient
☐ other: _____

5. **Expiration date** (mo/day/yr)

6.
model # _____
catalog # _____
serial # _____
lot # _____
other #

7. **If implanted, give date** (mo/day/yr)

8. **If explanted, give date** (mo/day/yr)

9. **Device available for evaluation?** (Do not send to FDA)
☐ yes ☐ no ☐ returned to manufacturer on _____ (mo/day/yr)

10. **Concomitant medical products** and therapy dates (exclude treatment of event)

E. Reporter (see confidentiality section on back)

1. **Name & address**

phone #

2. **Health professional?**
☐ yes ☐ no

3. **Occupation**

4. **Also reported to**
☐ manufacturer
☐ user facility
☐ distributor

5. **If you do NOT want your identity disclosed to the manufacturer, place an " X " in this box.** ☐

PLEASE TYPE OR USE BLACK INK

Mail to: **MEDWATCH**
5600 Fishers Lane
Rockville, MD 20852-9787

or FAX to:
1-800-FDA-0178

FDA Form 3500

Submission of a report does not constitute an admission that medical personnel or the product caused or contributed to the event.

ADVICE ABOUT VOLUNTARY REPORTING

Report adverse experiences with:

- medications (drugs or biologics)
- medical devices (including in-vitro diagnostics)
- special nutritional products (dietary supplements, medical foods, infant formulas)
- cosmetics
- medication errors

Report product problems – quality, performance or safety concerns such as:

- suspected contamination
- questionable stability
- defective components
- poor packaging or labeling
- therapeutic failures

Report SERIOUS adverse events. An event is serious when the patient outcome is:

- death
- life-threatening (real risk of dying)
- hospitalization (initial or prolonged)
- disability (significant, persistent or permanent)
- congenital anomaly
- required intervention to prevent permanent impairment or damage

Report even if:

- you're not certain the product caused the event
- you don't have all the details

How to report:

- just fill in the sections that apply to your report
- use section C for all products except medical devices
- attach additional blank pages if needed
- use a separate form for each patient
- report either to FDA or the manufacturer (or both)

Confidentiality: The patient's identity is held in strict confidence by FDA and protected to the fullest extent of the law. FDA will not disclose the reporter's identity in response to a request from the public, pursuant to the Freedom of Information Act. The reporter's identity, including the identity of a self-reporter, may be shared with the manufacturer unless requested otherwise.

If your report involves a serious adverse event with a device and it occurred in a facility outside a doctor's office, that facility may be legally required to report to FDA and/or the manufacturer. Please notify the person in that facility who would handle such reporting.

Important numbers:

- 1-800-FDA-0178 to FAX report
- 1-800-FDA-1088 to report by phone or for more information
- 1-800-822-7967 for a VAERS form for vaccines

To Report via the Internet:

https://www.accessdata.fda.gov/scripts/medwatch/

Public Health - Seattle & King County

Pharmaceutical Recall Policy

POLICY: 2002-01

FUNCTIONAL AREA: Pharmacy Warehouse, Pharmacies, Dispensaries **Proc. No.**: 01

DESCRIPTION: **This document will outline the procedures for a medication recall.**

REVIEWED:	Date:	REVISED:	Date:
APPROVED:	Date:	APPROVED:	Date:

Recall of Pharmaceuticals, vaccines, medical supplies purchased by Public Health – Seattle & King County Pharmacies and Central Pharmacy Warehouse

Public Health - Seattle & King County

Pharmaceutical Recall Policy

POLICY: 2002-01

FUNCTIONAL AREA: Pharmacy Warehouse, Pharmacies, Dispensaries **Proc. No.**: 01

DESCRIPTION: **This document will outline the procedures for a medication recall.**

REVIEWED:	Date:	REVISED:	Date:
APPROVED:	Date:	APPROVED:	Date:

Definition of a Recall

Recalls are actions taken by a manufacturer to remove a drug or product from the market. Recalls can be conducted by the manufacturers own initiative, by FDA request, or by FDA order under statutory authority.

A Class I recall is a situation in which there is a reasonable probability that the use of or exposure to a medication or product will cause adverse health consequences or death. A class II recall is a situation in which use of or exposure to the medication may cause temporary or a medically reversible adverse health outcome. Class III recalls involve products not likely to cause adverse health consequences.

A market withdrawal occurs when a product has a minor violation that would not be subject to FDA legal action. The firm removes the medication from the market or corrects the violation. For example, a medication that has been tampered with may be removed via a market withdrawal.

A medical device safety alert can also be issued in situations where a medical device may present an unreasonable risk of substantial harm. These situations may also be considered recalls.

Clinic Procedures:

If the recalled medication or product has been purchased and distributed by the Central Pharmacy Warehouse, then the Senior Pharmacist will fax a recall notice to each clinic site having purchased the product within the last 3 years. The faxed document will contain a response sheet that each clinic or clinic pharmacy is responsible for returning within 24 hours of receipt. The clinic manager or his or her agent will be responsible for reviewing, signing and returning the recall documents.

The faxed document will not contain instructions on contacting patients but will say: “Patient notification may be necessary. Please wait for additional instructions” or “Patient notification is not necessary”.

The faxed document will give the name, NDC and lot number(s) of the recalled product. See example, Appendix A. The recalled medication will be immediately removed from usage by the clinic manager or his/her agent and returned to Central Pharmacy with a copy of the recall fax response sheet.

The Central Pharmacy Warehouse will retain all records of recalls for 2 years and archive recalled documents for and additional 5 years. The Chief of Pharmacy will be responsible for sending all recall documentation, requiring patient notification, to Public Health Risk Management. This will include fax documents, response sheets from the clinics or pharmacies, patient notification logs, letter templates and FDA or manufacturer documents.

Deleted: years (please include notifying the chief of pharmacy of any recalls. This can be done via e-mail if not critical or via pager if critical).(what about medications that were not purchased through the warehouse, i.e.were purchased by the in-house pharmacy from the wholesaler or have obtained as samples

Deleted:

Deleted: . I would like to see the policy address having the warehouse staff notify the clinics of recalls for medications/devices that were obtained through the warehouse and also notify the clinic pharmacies of "any" medications

Deleted:

Deleted: recalls that are received.) Is it reasonable to have someone at the warehouse check the weekly FDA Enforcement Reports that are on the FDA website http://www.fda.gov

Public Health - Seattle & King County

Pharmaceutical Recall Policy

POLICY: 2002-01

FUNCTIONAL AREA: Pharmacy Warehouse, Pharmacies, Dispensaries **Proc. No.**: 01

DESCRIPTION: **This document will outline the procedures for a medication recall.**

REVIEWED:	Date:	REVISED:	Date:
APPROVED:	Date:	APPROVED:	Date:

Recall Procedures for the Pharmacy Warehouse:

Recalls will initiate in the Central Pharmacy Warehouse when notification is received from the manufacturer, FDA commercial wholesaler or distributor. The Senior Pharmacist will review the purchasing records to determine if the product in question has been purchased, issued or stored in the Central Pharmacy Warehouse. If no patient contact is necessary, a recall fax will be sent to clinics & pharmacies who have received product from the Central Pharmacy within 3 years. Details of the recall will be given to the Chief of Pharmacy via pager/voice contact immediately if patient notification is required and by voice mail or e-mail if no patient contact is required. The Chief of Pharmacy will notify the Department Medical Director, Program Medical Director, Division Management, Program Managers, Operations Managers and Risk Managers preferably via voice contact if necessary. The Senior pharmacist will also notify all pharmacy sites of any known drug recalls so that each pharmacists can review his or her stock on hand for recalled products.

The above staff will assess the impact of the recall in regard to patient safety, clinic workflow, staff safety, and department liability when drafting the patient notification plan. Program staff will take the lead in developing a work plan for the clinic, which will include documenting affected clients, documenting how to contact the affected clients, letter templates, and implementation plan. Program staff and operations management will ensure that the plan is communicated to clinic managers, clinic supervisors, PHASS's, on site pharmacists and clinic staff. Clinic management team will insure that the plan is implemented and return all documentation to the Chief of Pharmacy.

Recalls Procedures for Public Health – Seattle & King County Pharmacies:

Recall Notifications maybe received from the Central Pharmacy Warehouse, from an outside commercial wholesaler, distributor or manufacturer. The pharmacist will immediately remove all recalled items from the pharmacy area and quarantine from use. Recalled documents will be returned to the source wholesaler, distributor or manufacturer and a copy retained in the pharmacy for 2 years and archived for 5 years. Documentation including pharmacy records searched wholesaler logs and any other documentation will also be retained.

If the recall notification is from the Central Pharmacy Warehouse or concerns an item that maybe stocked within the clinic, the pharmacist will immediately notify the clinic manager of the recall. The clinic manager or agent will be responsible for removing the recalled item from within the clinic and documenting the action taken.

Each pharmacy is responsible for contacting the Chief of Pharmacy concerning the recalled item via pager. If patient notification is required, the Chief of Pharmacy will notify the Department Medical Director, Program Medical Director, Division Management, Program Managers, Operations Managers and Risk Managers preferably via voice contact.

Deleted: pager if patient notification is required

Public Health - Seattle & King County

Pharmaceutical Recall Policy

POLICY: 2002-01

FUNCTIONAL AREA: Pharmacy Warehouse, Pharmacies, Dispensaries **Proc. No.**: 01

DESCRIPTION: **This document will outline the procedures for a medication recall.**

REVIEWED:	Date:	REVISED:	Date:
APPROVED:	Date:	APPROVED:	Date:

Recalls Procedures for Public Health – Seattle & King County Pharmacies: cont.

The above staff will assess the impact of the recall in regard to patient safety, clinic workflow, staff safety, and department liability when drafting the patient notification plan. Program staff will take the lead in developing a work plan for the clinic, which will include documenting affected clients, documenting how to contact the affected clients, letter templates, implementation plan. Program staff and operations management will ensure that the plan is communicated to clinic managers, clinic supervisors, PHASS's, on site pharmacist and clinic staff. Clinic management team will insure that the plan is implemented and return all documentation to the Chief of Pharmacy.

Public Health - Seattle & King County

Pharmaceutical Recall Policy

POLICY: 2002-01

FUNCTIONAL AREA: Pharmacy Warehouse, Pharmacies, Dispensaries **Proc. No.**: 01

DESCRIPTION: **This document will outline the procedures for a medication recall.**

REVIEWED:	Date:	REVISED:	Date:
APPROVED:	Date:	APPROVED:	Date:

ParaGard® T 380A

INTRAUTERINE COPPER CONTRACEPTIVE

Prescribing Information

Patients should be counseled that this product does not protect against HIV infection (AIDS) and other sexually transmitted diseases.

The ParaGard® T380A should only be inserted, managed, and removed by clinicians that have demonstrated clinical competence for these procedures received under supervision.

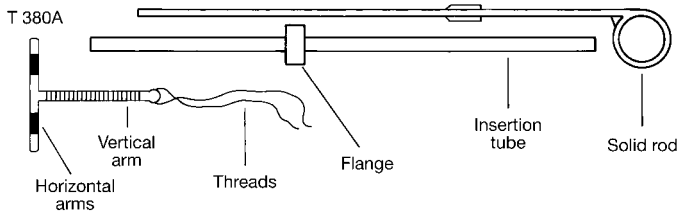
NOTICE

You have received a Patient Package Insert that Federal Regulations (21 CFR 310.502) require you to furnish to each patient who is considering the use of the ParaGard® T 380A.

The Patient Package Insert contains information on the safety and efficacy of the ParaGard® T 380A. Before inserting the ParaGard® T 380A:

- You should read the physician prescription labeling and be familiar with all the information it contains.
- You should counsel the patient and answer her questions about contraception, the ParaGard® T 380A, and the information in the Patient Package Insert.
- You and the patient should read each section of the Patient Package Insert, and if the patient agrees, she may sign a consent form provided for your convenience.

The Patient Package Insert is also available in Spanish and other foreign languages. Address requests to Ortho-McNeil Pharmaceutical, Inc. or telephone 1-800-322-4966.



DESCRIPTION

The polyethylene body of the ParaGard® T 380A is wound with approximately 176 mg of copper wire and carries a copper collar of approximately 68.7 mg of copper on each of its transverse arms. The exposed surface areas of copper are 380 ± 23 mm.^{2} The dimensions of the ParaGard® T 380A are 36 mm in the vertical direction and 32 mm in the horizontal direction. The tip of the vertical arm of the ParaGard® T 380A is enlarged to form a bulb having a diameter of 3 mm. The ParaGard® T 380A is equipped with a monofilament polyethylene thread which is tied through the bulb, resulting in two threads at the tip to aid in removal of the IUD. The ParaGard® T 380A contains barium sulfate to render it radiopaque.

The ParaGard® T 380A is packaged together with an insertion tube and solid rod in a Tyvek®-polyethylene pouch and then sterilized. The insertion tube is equipped with a movable flange to aid in gauging the depth to which the insertion tube is inserted through the cervical canal and into the uterine cavity.

CLINICAL PHARMACOLOGY

Available data indicate that the contraceptive effectiveness of the ParaGard® T 380A is enhanced by copper being released continuously from the copper coil and sleeves into the uterine cavity. The exact mechanism by which metallic copper enhances the contraceptive effect of an IUD has not been conclusively demonstrated. Various hypotheses have been advanced, including interference with sperm transport, fertilization, and implantation. Clinical studies with copper-bearing IUDs also suggest that fertilization is prevented either due to an altered number or lack of viability of spermatozoa.[1]

INDICATIONS AND USAGE

The ParaGard® T 380A is indicated for intrauterine contraception. ParaGard® T 380A is highly effective. Table II and Table III list an expected pregnancy rate for one year between 0.7 and 0.5, respectively. ParaGard® T 380A should not be kept in place longer than 10 years.

RECOMMENDED PATIENT PROFILE

The ParaGard® T 380A is recommended for women who have had at least one child, are in a stable, mutually monogamous relationship, and have no history of pelvic inflammatory disease.

CONTRAINDICATIONS

The ParaGard® T 380A should not be inserted when one or more of the following conditions exist:

1. Pregnancy or suspicion of pregnancy.
2. Abnormalities of the uterus resulting in distortion of the uterine cavity.
3. Acute pelvic inflammatory disease or a history of pelvic inflammatory disease.
4. Postpartum endometritis or infected abortion in the past 3 months.
5. Known or suspected uterine or cervical malignancy, including unresolved, abnormal "Pap" smear.
6. Genital bleeding of unknown etiology.
7. Untreated acute cervicitis or vaginitis, including bacterial vaginosis, until infection is controlled.
8. Copper-containing IUDs should not be inserted in the presence of diagnosed Wilson's disease.
9. Known allergy to copper.
10. Patient or her partner has multiple sexual partners.
11. Conditions associated with increased susceptibility to infections with microorganisms. Such conditions include, but are not limited to, leukemia, acquired immune deficiency syndrome (AIDS), and I.V. drug abuse.
12. Genital actinomycosis.
13. A previously inserted IUD that has not been removed.

WARNINGS

1. PREGNANCY

Effects on the offspring when pregnancy occurs with the ParaGard® T 380A in place are unknown.

a. **Septic Abortion**

Reports indicate an increased incidence of septic abortion with septicemia, septic shock, and death in patients becoming pregnant with an IUD in place. Most of these reports have been associated with, but are not limited to, the mid-trimester of pregnancy. In some cases, the initial symptoms have been insidious and not easily recognized. If pregnancy should occur with an IUD *in situ*, the IUD should be removed if the string is visible and removal is easily accomplished. Of course, manipulation may result in spontaneous abortion. If removal proves to be difficult, or if threads are not visible, interruption of the pregnancy should be considered and offered as an option. Rates of mortality with and without contraception are shown in Table I.

b. **Continuation of Pregnancy**

If the patient elects to maintain the pregnancy and the IUD remains *in situ,* she should be warned that there is an increased risk of spontaneous abortion and sepsis. In addition, she is at increased risk of premature labor and delivery. As a consequence of premature birth, the fetus is at increased risk of damage. She should be followed more closely than the usual obstetrical patient. The patient must be advised to report immediately all abnormal symptoms, such as flu-like syndrome, fever, abdominal cramping or pain, bleeding or vaginal discharge, because generalized symptoms of septicemia may be insidious.

2. ECTOPIC PREGNANCY

a. Patients with a history of ectopic pregnancy are at an increased risk of subsequent pregnancies being ectopic. Although current data indicate that there is no increased risk of ectopic pregnancy in patients using the ParaGard® T 380A and some data suggest there may be a lower risk than the general population using no method of contraception, a pregnancy which occurs with the ParaGard® T 380A in place is more likely to be ectopic than a pregnancy occurring without ParaGard® T 380A.[2-4] Therefore, patients who become pregnant while using the ParaGard® T 380A should be carefully evaluated for the possibility of an ectopic pregnancy.

b. Special attention should be directed to patients with delayed menses, slight metrorrhagia and/or unilateral pelvic pain, and to those patients who wish to terminate a pregnancy because of IUD failure, to determine whether ectopic pregnancy has occurred.

3. PELVIC INFECTION (PELVIC INFLAMMATORY DISEASE, PID)

The ParaGard® T 380A is contraindicated in the presence of PID or in women with a history of PID. Use of all IUDs, including the ParaGard® T 380A, has been associated with an increased incidence of PID. Therefore, a decision to use the ParaGard® T 380A must include consideration of the risks of PID. The highest rate of PID has been reported to occur after insertion and up to four months thereafter. A study suggests that the highest incidence occurs within 20 days postinsertion, then falls, remaining constant thereafter.[5] Administration of prophylactic antibiotics has been reported, although studies do not confirm the utility of this prophylactic measure in reducing PID. PID can necessitate hysterectomy and can also lead to tubo-ovarian abscesses, tubal occlusion and infertility, and tubal damage that can predispose to ectopic pregnancy. PID can result in peritonitis and, infrequently, in death. The effect of PID on fertility is especially important for women who may wish to have children at a later date.

a. **Women at special risk of PID**

The risk of PID appears to be greater for women who have multiple sexual partners and also for those women whose sexual partners have multiple sexual partners, as PID is most frequently caused by sexually transmitted diseases.

b. **PID warning to ParaGard® T 380A users**

All women who choose the ParaGard® T 380A must be informed prior to insertion that IUD use has been associated with an increased incidence of PID and that PID can necessitate hysterectomy, can cause tubal damage leading to ectopic pregnancy or infertility or, in infrequent cases, can cause death. Patients must be taught to recognize and report to their physician promptly any symptoms of pelvic inflammatory disease. These symptoms include development of menstrual disorders (prolonged or heavy bleeding), unusual vaginal discharge, abdominal or pelvic pain or tenderness, dyspareunia, chills, and fever.

c. **Asymptomatic PID**

PID may be asymptomatic but still result in tubal damage and its sequelae.[6,7]

d. **Treatment of PID**

Following diagnosis of PID, or suspected PID, bacteriologic specimens should be obtained and antibiotic therapy should be initiated promptly. Removal of the ParaGard® T 380A after initiation of antibiotic therapy is usually appropriate. Time should be allowed for therapeutic blood levels to be reached prior to removal. Guidelines for PID treatment are available from the Center for Disease Control (CDC), Atlanta, Georgia. A copy of the printed guidelines has been provided to you by Ortho-McNeil Pharmaceutical, Inc. The guidelines were established after deliberation by a group of experts and staff of the CDC, but they should not be construed as rules suitable for use in all patients. Adequate PID treatment requires the application of current standards of therapy prevailing at the time of occurrence of the infection with reference to the prescription labeling of the antibiotic selected.

Genital actinomycosis has been associated primarily with long-term IUD use. If actinomycosis occurs, promptly institute appropriate antibiotic therapy and remove the ParaGard® T 380A.

4. EMBEDMENT

Partial penetration or embedment of the ParaGard® T 380A in the endometrium or myometrium can result in difficult removal. In some cases this can result in breakage of the IUD, necessitating surgical removal.

5. PERFORATION

Partial or total perforation of the uterine wall or cervix may occur with use of the ParaGard® T 380A. The rate of perforation in randomized trials of the ParaGard® T 380A has been 1 in 1,360. Insertions immediately after the expulsion of the placenta are not known to be associated with increased risks of perforation, but insertion later in the first postpartum month, particularly during lactation, has been associated with an increased risk of perforation.[8,9] Thus, unless performed immediately postpartum, insertion should be delayed to the second postpartum month. IUD insertion immediately postabortion in the first trimester is not known to be associated with increased risks of perforation, but insertion after second trimester abortion should be delayed until the second postabortion month.

The possibility of perforation must be kept in mind during insertion and at the time of any subsequent examination. If perforation occurs, the ParaGard® T 380A should be removed as soon as possible. A surgical procedure may be required. Abdominal adhesions, intestinal penetration, intestinal obstruction, and local inflammatory reaction with abscess formation and erosion of adjacent viscera may result if the ParaGard® T 380A is left in the peritoneal cavity. There are reports of migration after insertion.

6. MEDICAL DIATHERMY

The use of medical diathermy (short-wave and microwave) in a patient with a metal-containing IUD may cause heat injury to the surrounding tissue. Therefore, medical diathermy to the abdominal and sacral areas should not be used on patients with a ParaGard® T 380A in place.

7. EFFECTS OF COPPER

Additional amounts of copper available to the body from the ParaGard® T 380A may precipitate symptoms in women with Wilson's disease. The incidence of Wilson's disease is approximately 1 in 200,000. The long term effects of intrauterine copper to a child conceived in the presence of an IUD are unknown.

8. RISKS OF MORTALITY

The available data from a variety of sources have been analyzed to estimate the risk of death associated with various methods of contraception. The estimates of risk of death include the combined risk of the contraceptive method plus the risk of pregnancy or abortion in the event of method failure. The findings of the analysis are shown in Table I.[10]

TABLE I – Annual Number of Birth-Related or Method-Related Deaths Associated with Control of Fertility per 100,000 Non-sterile Women, by Fertility Control Method According to Age

	Age Group					
Methods	**15-19**	**20-24**	**25-29**	**30-34**	**35-39**	**40-44**
No Birth Control Method/Term	4.7	5.4	4.8	6.3	11.7	20.6
No Birth Control Method/AB	2.1	2.0	1.6	1.9	2.8	5.3
IUD	0.2	0.3	0.2	0.1	0.3	0.6
Periodic Abstinence	1.4	1.3	0.7	1.0	1.0	1.9
Withdrawal	0.9	1.7	0.9	1.3	0.8	1.5
Condom	0.6	1.2	0.6	0.9	0.5	1.0
Diaphragm/Cap	0.6	1.1	0.6	0.9	1.6	3.1
Sponge	0.8	1.5	0.8	1.1	2.2	4.1
Spermicides	1.6	1.9	1.4	1.9	1.5	2.7
Oral Contraceptives	0.8	1.3	1.1	1.8	1.0	1.9
Implants/Injectables	0.2	0.6	0.5	0.8	0.5	0.6
Tubal Sterilization	1.3	1.2	1.1	1.1	1.2	1.3
Vasectomy	0.1	0.1	0.1	0.1	0.1	0.2

PRECAUTIONS

Patients should be counseled that this product does not protect against HIV infection (AIDS) and other sexually transmitted diseases.

1. Patient Counseling

Prior to the insertion, the physician, nurse, or other trained health professional must provide the patient with the Patient Package Insert. The patient should be given the opportunity to read the information and discuss fully any questions she may have concerning the ParaGard® T 380A as well as other methods of contraception.

2. Patient Evaluation and Clinical Considerations

a. A complete medical and social history, including that of the partner, should be obtained to determine conditions that might influence the selection of an IUD. A physical examination should include a pelvic examination, a "Pap" smear, and appropriate tests for any other forms of genital disease, such as gonorrhea and chlamydia laboratory evaluations, if indicated. If actinomyces-like organisms are detected on the Pap smear, they should be cultured to determine whether genital actinomyces is present. The physician should determine that the patient is not pregnant.

b. The uterus should be carefully sounded prior to the insertion to determine the degree of patency of the endocervical canal and the internal os, and the direction and depth of the uterine cavity. In occasional cases, severe cervical stenosis may be encountered. Do not use excessive force to overcome this resistance.

c. The uterus should sound to a depth of 6 to 9 centimeters (cm). Insertion of an IUD into a uterine cavity measuring less than 6.0 cm by sounding may increase the incidence of expulsion, bleeding, pain, perforation, and possibly, pregnancy.

d. Clinicians are cautioned that it is imperative for them to become thoroughly familiar with the instructions for use before attempting placement of the ParaGard® T 380A. To reduce the possibility of insertion in the presence of an existing undetermined pregnancy, the optimal time for insertion is the latter part of the menstrual period, or one or two days thereafter. The ParaGard® T 380A should not be inserted postpartum or postabortion until involution of the uterus is complete. The incidence of perforation and expulsion is greater if involution is not complete. Data also suggest that there may be an increased risk of perforation and expulsion if the woman is lactating.[8,9] Other recent studies report no increased incidence of perforation or expulsion in lactating women.[11,12]

The ParaGard® T 380A should be placed at the fundus of the uterine cavity. Proper placement enhances contraceptive effectiveness and helps avoid perforation and partial or complete expulsion that could result in pregnancy.

e. Patients experiencing menorrhagia and/or metrorrhagia following IUD insertion may be at risk for the development of hypochromic microcytic anemia. Careful consideration of this risk must be given before insertion in patients with anemia or a history of menorrhagia or hypermenorrhea. Patients receiving anticoagulants or having a coagulopathy may have a greater risk of menorrhagia or hypermenorrhea.

f. Syncope, bradycardia, or other neurovascular episodes may occur during insertion or removal of IUDs, especially in patients with a previous disposition to these conditions or cervical stenosis.

g. Use of an IUD in patients with cervicitis should be postponed until treatment has eradicated the infection.

h. Patients with valvular or congenital heart disease are more prone to develop subacute bacterial endocarditis than patients who do not have valvular or congenital heart disease. Use of an IUD in these patients may represent a potential source of septic emboli. Patients with known congenital heart disease who may be at increased risk should be treated with appropriate antibiotics at the time of insertion.

i. Patients requiring chronic corticosteroid therapy or insulin for diabetes should be monitored with special care for infection.

j. Since the ParaGard® T 380A may be partially or completely expelled, patients should be reexamined and evaluated shortly after the first postinsertion menses, but no later than 3 months afterwards. Thereafter, annual examination with appropriate evaluation, including a "Pap" smear, should be carried out. The ParaGard® T 380A should be kept in place no longer than 10 years.

k. The patient should be told that some bleeding or cramps may occur during the first few weeks after insertion. If these symptoms continue or are severe she should report them to her physician. She should be instructed on how to check to make certain that the threads still protrude from the cervix and cautioned that there is no contraceptive protection if the ParaGard® T 380A has been expelled. She should check frequently, at least after each menstrual period. She should be cautioned not to dislodge the ParaGard® T 380A by pulling on the thread. If a partial expulsion occurs, removal is indicated.

l. Rarely, a copper-induced urticarial allergic skin reaction may develop in women using a copper-containing IUD. If the symptoms of such an allergic response occur, the patient should be instructed to tell the consulting physician that a copper-containing device is being used.

m. The effect of magnetic resonance imaging of the pelvis was investigated in one study[13] in women with the CU-7® (Intrauterine Copper Contraceptive) and the LIPPES LOOP™ IUD. The CU-7® has a different configuration and contains less copper than the ParaGard® T 380A. The results of the study indicate that neither the CU-7® nor the LIPPES LOOP™ were moved under the influence of the magnetic field nor did they heat during the spin-echo sequences usually employed for pelvic imaging.

3. Insertion Prophylaxis

Observe strict asepsis at insertion; clean the endocervix with an antiseptic solution, because the presence of organisms capable of establishing PID cannot be determined by appearance, and because IUD insertion may be associated with introduction of vaginal bacteria into the uterus. Data do not confirm the utility of prophylactic administration of antibiotics in reducing the incidence of PID, and their use in nursing women is not recommended.

4. Requirements for Continuation and Removal

a. The ParaGard® T 380A must be replaced before the end of the tenth year of use. There is no evidence of decreasing contraceptive efficacy with time before ten years, but the contraceptive effectiveness at longer times has not been established; therefore, the patient should be informed of the known duration of contraceptive efficacy and be advised to return in 10 years for removal and possible insertion of a new ParaGard® T 380A.

b. The ParaGard® T 380A should be removed for the following medical reasons: menorrhagia-and/or metrorrhagia-producing anemia; pelvic infection; genital actinomycosis; intractable pelvic pain; dyspareunia; pregnancy, endometrial or cervical malignancy; uterine or cervical perforation; increase in length of the threads extending from the cervix, or any other indication of partial expulsion. Insertions immediately following placental delivery or first trimester abortion may result in threads becoming slightly longer as the uterus involutes and may not represent expulsion or partial expulsion.

c. If the retrieval threads cannot be visualized, they may have retracted into the uterus or have been broken, or the ParaGard® T 380A may have been broken, or the ParaGard® T 380A may have been expelled. Localization may be made by feeling with a probe, X-ray, or sonography. When the physician elects to recover a ParaGard® T 380A with the threads not visible, the removal instructions should be reviewed.

d. Should the patient's relationship cease to be mutually monogamous, or should her partner become HIV positive, or acquire a sexually transmitted disease, she should be instructed to report this change to her clinician immediately. It may be advisable to recommend the use of a barrier method as a partial protection against acquiring sexually transmitted diseases until the ParaGard® T 380A can be removed.

5. Continuing Care of Patients Using ParaGard® T 380A

a. Any inquiries regarding pain, odorous discharge, bleeding, fever, genital lesions or sores, or a missed period should be promptly responded to and prompt examination is recommended.

b. If examination during visits subsequent to insertion reveals that the length of the threads has visibly or palpably changed from the length at time of insertion, the ParaGard® T 380A should be considered displaced and should be removed. A new ParaGard® T 380A may be inserted at that time or during the next menses if it is certain that conception has not occurred. Under no circumstances should reinsertion with an expelled ParaGard® T 380A be attempted. A new ParaGard® T 380A should be inserted.

c. Since the ParaGard® T 380A may be partially or completely expelled, patients should be reexamined and evaluated shortly after the first postinsertion menses, but no later than 3 months afterwards. Thereafter, at least annual examination with appropriate evaluation, including a "Pap" smear, and if indicated, gonococcal and chlamydial laboratory evaluations, should be carried out. The ParaGard® T 380A should be kept in place no longer than 10 years.

d. In the event a pregnancy is confirmed during ParaGard® T 380A use, the following steps should be taken:

- Determine whether the pregnancy is ectopic and take appropriate measures if it is.
- Inform patient of the risks of leaving an IUD *in situ* or removing it during pregnancy, and of the lack of data on the long term effects of the ParaGard® T 380A on the offspring of women who have had it *in utero* during conception or gestation (see WARNINGS). This information should include the risk of septic spontaneous abortion with the IUD *in situ*.
- If possible, the ParaGard® T 380A should be removed after the patient has been warned of the risks of removal. If removal is difficult, the patient should be counseled about and offered pregnancy termination.
- If the ParaGard® T 380A is left in place, the patient's course should be followed closely.

ADVERSE REACTIONS

These adverse reactions are not listed in any order of frequency or severity.

Reported adverse reactions with intrauterine contraceptives include: endometritis; spontaneous abortion; septic abortion; septicemia; perforation of the uterus and cervix; embedment; fragmentation of the IUD; pelvic infection; tubo-ovarian abscess; tubal damage; vaginitis; leukorrhea; cervical erosion; pregnancy; ectopic pregnancy; fetal damage; difficult removal; complete or partial expulsion of the IUD, particularly in those patients with uteri measuring less than 6.0 cm by sounding; menstrual spotting; prolongation of menstrual flow; anemia; amenorrhea or delayed menses; pain and cramping; dysmenorrhea; backaches; dyspareunia; neurovascular episodes, including bradycardia and syncope secondary to insertion. Uterine perforation and IUD displacement into the abdomen have been followed by peritonitis, abdominal adhesions, intestinal penetration, intestinal obstruction, and cystic masses in the pelvis. (Certain of these adverse reactions can lead to loss of fertility, partial or total removal of reproductive organs, hormonal imbalance, or death.) Urticarial allergic skin reaction may occur.

CLINICAL STUDIES

Different event rates have been reported with the use of different intrauterine contraceptives. Inasmuch as these rates are usually derived from separate studies conducted by different investigators in several populations, they cannot be compared with precision. Considerably different rates are likely to be obtained because event rates per unit of time tend to decrease as studies are extended, since more susceptible subjects discontinue due to expulsions, adverse reactions, or pregnancy, leaving the study population richer in less susceptible subjects. In clinical trials conducted by The Population Council[14,15] and WHO, use-effectiveness of the ParaGard® T 380A as calculated by the life table method was determined through ten (10) years of use.

Data suggest a higher pregnancy rate in women under 20.[14,15,17]

TABLE II

ParaGard® T 380A
(Intrauterine Copper Contraceptive)

GROSS ANNUAL TERMINATION AND CONTINUATION RATES PER 100* USERS
All Copper T 380A IUD Acceptors
Combined Population Council and WHO Studies

	YEAR									
Rate of Item	1	2	3	4	5	6	7	8	9	10
Pregnancy	0.7	0.3	0.6	0.2	0.3	0.2	0.0	0.4	0.0	0.0
Expulsion	5.7	2.5	1.6	1.2	0.3	0.0	0.6	1.7	0.2	0.4
Bleeding/Pain	11.9	9.8	7.0	3.5	3.7	2.7	3.0	2.5	2.2	3.7
Other Medical	2.5	2.1	1.6	1.7	0.1	0.3	1.0	0.4	0.7	0.3
Continuation	76.8	78.3	81.2	86.2	89.0	91.9	87.9	88.1	92.0	91.8
No. of Women:										
At Start of Year	4932	3149	2018	1121	872	621	563	483	423	325
At End of Year	3149	2018	1121	872	621	563	483	423	325	230

*Rates were calculated by weighing the annual rates by the number of subjects starting each year for each of the Population Council (3536 acceptors) and the World Health Organization (1396 acceptors) trials.

TABLE III

GROSS ANNUAL EVENT RATES PER 100 CONTINUING USERS BY YEAR AND PARITY

	1 Year Parous
Pregnancy	0.5
Expulsion	2.3
Bleeding/Pain	3.4
Infection	0.3
Other Medical	0.5
Planning Pregnancy	0.6
Other Personal	0.7
Continuation	92.1
No. Completed	1842.0

Rates were calculated by combining the experience on a weighted basis from both an international study by the World Health Organization (2110 women) and a U.S. study by GynoPharma Inc. (230 women).

The lowest expected and typical failure rates during the first year of continuous use of all contraceptive methods are listed in Table IV (Adapted from Reference 16).

TABLE IV - Percentage of women experiencing a contraceptive failure during the first year of typical use and the first year of perfect use and the percentage continuing use at the end of the first year, United States.[16]

	% of Women Experiencing an Accidental Pregnancy Within the First Year of Use		% of Women Continuing Use at One Year[3]
Method	**Typical Use[1]**	**Perfect Use[2]**	
Chance[4]	85	85	
Spermicides[5]	21	6	43
Periodic Abstinence	20		67
Calendar		9	
Ovulation Method		3	
Sympto-Thermal[6]		2	
Post-Ovulation		1	
Withdrawal	19	4	
Cap[7]			
Parous Women	36	26	45
Nulliparous Women	18	9	58
Sponge			
Parous Women	36	20	45
Nulliparous Women	18	9	58
Diaphragm[7]	18	6	58
Condom[8]			
Female (Reality)	21	5	56
Male	12	3	63
Pill	3		72
Progestin Only		0.5	
Combined		0.1	
IUD			
Progesterone T	2.0	1.5	81
Copper T 380A (ParaGard® T 380A)	0.8	0.6	78
Depo-Provera®	0.3	0.3	70
Norplant® (6 Capsules)	0.09	0.09	85
Female Sterilization	0.4	0.4	100
Male Sterilization	0.15	0.10	100

Emergency Contraceptive Pills: Treatment initiated within 72 hours after unprotected intercourse reduces the risk of pregnancy by at least 75%.[9]

Lactational Amenorrhea Method: LAM is a highly effective temporary method of contraception.[10]

Footnotes to Table IV:

1. Among *typical* couples who initiate use of a method (not necessarily for the first time), the percentage who experience an accidental pregnancy during the first year if they do not stop use for any other reason.
2. Among couples who initiate use of a method (not necessarily for the first time) and who use it *perfectly* (both consistently and correctly), the percentage who experience an accidental pregnancy during the first year if they do not stop use for any other reason.
3. Among couples attempting to avoid pregnancy, the percentage who continue to use a method for one year.
4. The percentages failing in columns (2) and (3) are based on data from populations where contraception is not used and from women who cease using contraception in order to become pregnant. Among such populations, about 89% become pregnant within one year. This estimate was lowered slightly (to 85%) to represent the percentage who would become pregnant within 1 year among women now relying on reversible methods of contraception if they abandoned contraception altogether.
5. Foams, creams, gels, vaginal suppositories, and vaginal film.
6. Cervical mucous (ovulation) method supplemented by calendar in the pre-ovulatory and basal body temperature in the post-ovulatory phases.
7. With spermicidal cream or jelly.
8. Without spermicides.
9. The treatment schedule is one dose as soon as possible (but no more than 72 hours) after unprotected intercourse, and a second dose 12 hours after the first dose. The hormones that have been studied in the clinical trials of postcoital hormonal contraception are found in Nordette, Levlen, Lo/Ovral (1 dose is 4 pills), Triphasil, Tri-Levlen (1 dose is 4 yellow pills), and Ovral (1 dose is 2 pills).
10. However, to maintain effective protection against pregnancy, another method of contraception must be used as soon as menstruation resumes, the frequency or duration of breastfeeds is reduced, bottle feeds are introduced, or the baby reaches 6 months of age.

HOW SUPPLIED

Available in cartons of one (NDC 54765-380-01) or five (NDC 54765-380-05) sterile units. Each ParaGard® T 380A is packaged in a Tyvek®-polyethylene pouch, together with an insertion tube and solid rod.

INSTRUCTIONS FOR USE

ParaGard® T 380A
(Intrauterine Copper Contraceptive)

CLINICIANS SHOULD HAVE DEMONSTRATED CLINICAL COMPETENCE IN PARAGARD® T 380A INSERTIONS, MANAGEMENT, AND REMOVAL RECEIVED UNDER SUPERVISION. PREVIOUS EDUCATION RE: SURGICAL PROCEDURES WILL REQUIRE VARYING LEVELS OF EXPERIENCE.

The ParaGard® T 380A (Intrauterine Copper Contraceptive) represents a different design in intrauterine contraceptives. Physicians are, therefore, cautioned that they should become thoroughly familiar with instructions for insertion before attempting placement of the ParaGard® T 380A. The insertion technique is different in several respects from that employed with other intrauterine contraceptives and the physician should pay particular attention to the drawings and commentary accompanying these instructions.

A single ParaGard® T 380A is placed at the fundus of the uterine cavity.

The ParaGard® T 380A may be inserted at any time during the cycle. However, it is essential that pregnancy be ruled out before insertion.

The ParaGard® T 380A is indicated for use up to 10 years. Therefore, the ParaGard® T 380A must be removed and a new one inserted on or before 10 years from the date of insertion.

PRELIMINARY PREPARATION AND INSERTION

1. Before insertion, you and the patient will want to review the Patient Package Insert. If the patient agrees, she may sign the Consent Form provided for your records.
2. Take a medical and social history.
3. Refer to CONTRAINDICATIONS, WARNINGS, and PRECAUTIONS.
4. Pelvic examination is to be performed prior to insertion of the ParaGard® T 380A, including a cervical "Pap" smear, and gonococcal and chlamydial evaluations, if indicated, and any other necessary specific tests.
5. If appropriate, commence antibiotic prophylaxis one hour before insertion.
6. Use of aseptic technique during insertion is essential.
7. The endocervix should be cleansed with an antiseptic solution and a tenaculum applied to the cervix with downward traction for correction of the angulation as well as stabilization of the cervix.
8. With a speculum in place, gently insert a sterile sound to determine the depth and direction of the uterine canal. Be sure to determine the position of the uterus before insertion.

CAUTION

Any intrauterine procedure can result in severe pain, bradycardia, and syncope.

It is generally believed that perforations, if they occur, are encountered at the time of insertion, although the perforation may not be detected until some time later. The position of the uterus should be determined during the preinsertion examination. Great care must be exercised during the preinsertion sounding and subsequent insertion. No attempt should be made to force the insertion.

HOW TO LOAD AND INSERT ParaGard® T 380A

STEP 1

To minimize the chance of introducing contamination, do not remove the ParaGard® T 380A from the insertion tube prior to placement in the uterus. Do not bend the arms of the ParaGard® T 380A earlier than 5 minutes before it is to be introduced into the uterus.

In the absence of sterile gloves, this can be accomplished without destroying sterility by folding the arms in the partially opened package. Place the partially opened package on a flat surface and pull the solid rod partially from the package so it will not interfere with assembly. Place thumb and index finger on top of package on ends of the horizontal arms. Push insertion tube against arms of ParaGard® T 380A as indicated by arrow in Fig. 1A to start arms folding.

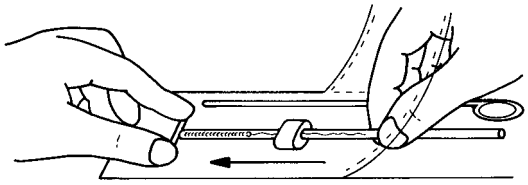


Fig. 1A

Complete the bending by bringing the thumb and index finger together using the other hand to maneuver the insertion tube to pick up the arms of the ParaGard® T 380A (Fig. 1B). Insert no further than necessary to insure retention of the arms. Introduce the solid rod into the insertion tube from the bottom alongside the threads until it touches the bottom of the ParaGard® T 380A.

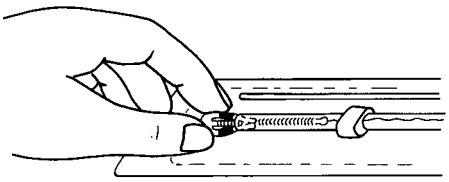


Fig. 1B

STEP 2

Adjust the movable flange so that it indicates the depth to which the ParaGard® T 380A should be inserted and the direction in which the arms of the ParaGard® T 380A will open. At this point, make certain that the horizontal arms of the ParaGard® T 380A and the long axis of the flange lie in the same horizontal plane. Introduce the loaded insertion tube through the cervical canal and upwards until the ParaGard® T 380A lies in contact with the fundus. The movable flange should be at the cervix (Fig. 2).

DO NOT FORCE THE INSERTION.

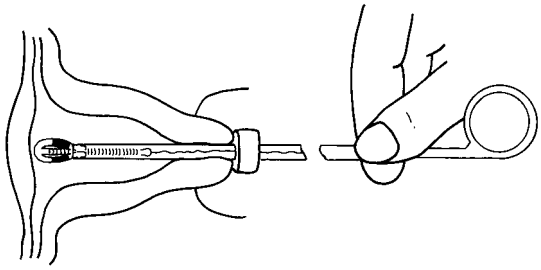


Fig. 2

STEP 3

To release the arms of the ParaGard® T 380A, withdraw the insertion tube not more than ½ inch while the solid rod is not permitted to move. This releases the arms of the ParaGard® T 380A (Fig. 3).

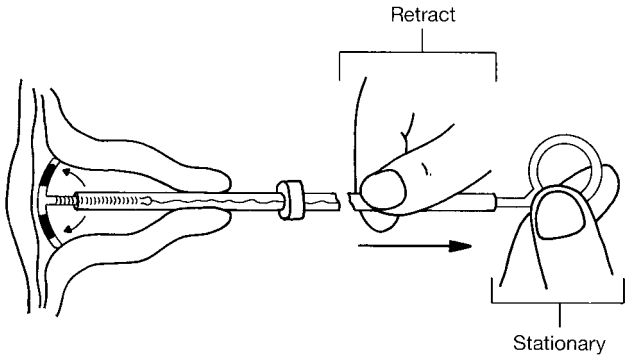


Fig. 3

STEP 4

After the arms are released, the insertion tube should be moved upward gently, until the resistance of the fundus is felt. This will assure placement of the T at the highest possible position within the endometrial cavity (Fig. 4).

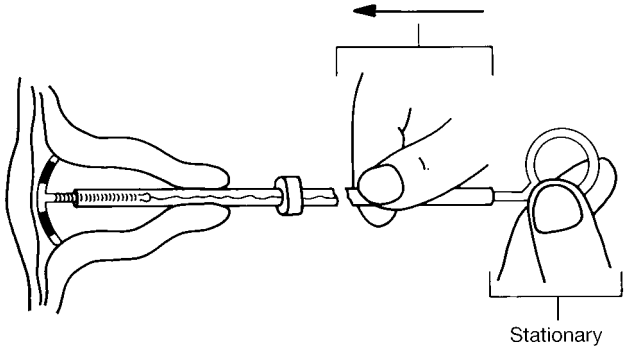


Fig. 4

STEP 5

Withdraw the solid rod while holding the insertion tube stationary (Fig. 5).

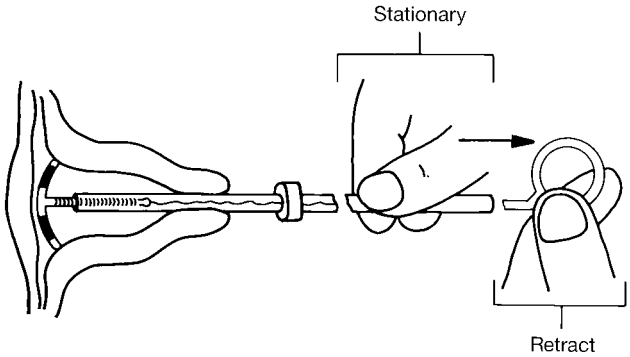


Fig. 5

STEP 6

Withdraw the insertion tube from the cervix. Be sure sufficient length of the threads are visible (approximately 1 in. or 2.5 cm.) to facilitate checking for the presence of the ParaGard® T 380A (Fig. 6). Notation of length of the threads should be made in patient record.

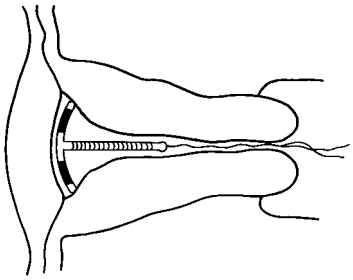


Fig. 6

HOW TO REMOVE ParaGard® T 380A

To remove the ParaGard® T 380A, pull gently on the exposed threads. The arms of the ParaGard® T 380A will fold upwards as it is withdrawn from the uterus. Even if removal proves difficult, the ParaGard® T 380A should not remain in the uterus after 10 years.

REFERENCES

1. Alvarez F et al: New insights on the mode of action on intrauterine contraceptives in women. *Fertil Steril* 1988; 49:768-773.
2. World Health Organization's Special Programme of Research, Development and Research Training in Human Reproduction: A multinational case-control study of ectopic pregnancy. *Clin Reprod Fertil* 1985; 3:131-143.
3. Ory HW, Women's Health Study: Ectopic pregnancy and intrauterine contraceptive devices: New perspectives. *Obstet Gynecol* 1981; 57:137-144.
4. Marchbanks PA et al: Risk factors for ectopic pregnancy: A population-based study. *JAMA* 1988; 259:1823-1827.
5. Farley TMM et al: Intrauterine devices and pelvic inflammatory disease: An international perspective. *Lancet* 1992; 339:785-788.
6. Cramer DW et al: Tubal infertility and the intrauterine device. *N Engl J Med* 1985; 312:941-947.
7. Daling JR et al: Primary tubal infertility in relation to the use of an intrauterine device. *N Engl J Med* 1985; 312:937-941.
8. Heartwell SF, Schlesselman S: Risk of uterine perforation among users of intrauterine devices. *Obstet Gynecol* 1983; 61:31-36.
9. Chi I-C, Kelly E: Is lactation a risk factor of IUD and sterilization-related uterine perforations? A hypothesis. *Int J Gynaecol Obstet* 1984; 22:315-317.
10. Harlap S, Kost K, Forrest JD: Preventing pregnancy, protecting health: a new look at birth control choices in the United States. The Alan Guttmacher Institute 1991; 1-129.
11. Chi I-C et al: Performance of the Copper T 380A Intrauterine device in breast feeding women. *Contraception* 1989; 39:603-618.
12. Farr G, Rivera R: Interactions between intrauterine contraceptive device use and breast-feeding status at time of intrauterine contraceptive device insertion. Analysis of TCu-380A acceptors in developing countries. *Am J Obstet Gynecol* 1992; 167:144-151.
13. Mark AS, Hricak H: Intrauterine contraceptive devices: MR imaging. *Radiology* 1987; 311-314.
14. Sivin I, Stern J: Long-acting, more effective Copper T IUDs: A summary of US experience, 1970-1975. *Stud Fam Plann* 1979; 10:263-281.
15. Sivin I, Schmidt F: Effectiveness of IUDs: A review. *Contraception* 1987; 36:55-84.
16. Trussell J: The Essentials of Contraception, in R.A. Hatcher, et al: *Contraceptive Technology*, 16th Revised Ed., New York, Irvington, 1994, p. 113-114.
17. World Health Organization (WHO): Mechanism of action, safety, and efficacy of intrauterine devices. Report of a WHO Scientific Group. Technical Report Series 753. Geneva; World Health Organization, 1987, p. 22.

ORTHO-McNEIL

Manufactured for
ORTHO-McNEIL PHARMACEUTICAL, INC.
Raritan, New Jersey 08869
by FEI Products, Inc.
N. Tonawanda, New York 14120

Revised September 2000

10U0732
631-40-410-5

WOMEN'S HEALTH

ParaGard® Patient Assistance Program

825 Wurlitzer Drive, No. Tonawanda, NY 14120
P 1.800.322.4966 F 1.877.843.8790 www.paragard.com

Our goal is to help you provide ParaGard® for your low-income patients who do not have insurance coverage for ParaGard®. We have streamlined the application process so that you will be able to receive ParaGard® quickly for these patients. To initiate the process, you and your patient must complete the application form on the back of this page. Simply mail or fax the completed form to the address above. If this is the first time your office is ordering ParaGard®, you will also be asked to fill out a business application form and to submit a copy of your healthcare professional's state license.

You may also call us beforehand, at 1-800-322-4966, to discuss whether a specific patient is likely to be eligible for assistance.

A case coordinator will review the completed application within 5-10 business days from the time of receipt. We will then notify you and your patient in writing of her eligibility status. If the application is approved, one ParaGard® will be sent directly to your office for the patient. A signature is required at the time of delivery.

Who may qualify for Patient Assistance for ParaGard®

For financial assistance, your patient must meet these basic requirements:

- She does not have private or government health insurance coverage for ParaGard®
- She meets income criteria established by the Federal Poverty Guidelines
- She is a citizen or documented resident of the U.S.

The FEI Women's Health Patient Assistance Program is voluntary and may be changed or ended at any time.

FEI Women's Health
ParaGard® Patient Assistance Program

825 Wurlitzer Drive, No. Tonawanda, NY 14120 P 1.800.322.4966 F 1.877.843.8790 www.paragard.com

PATIENT INFORMATION

First name MI Last name

Street address Apt #

City State Zip code

( ) Phone Email

☐☐/☐☐/☐☐ Date of birth (mm/dd/yy)

I guarantee that I do not have insurance coverage for ParaGard®
❑ Yes ❑ No

Number of children _____

Current gross annual household income $ _____

Number of household members dependent on income _____ (including patient)

Patient's Verification and Signature

I promise that the information on this form is correct and complete. If needed, FEI Women's Health LLC may request and obtain information about my or my family's income to ensure eligibility for this program and/or to ensure the accuracy and completeness of this application. I understand that the FEI Women's Health ParaGard® Patient Assistance Program has the right to modify or discontinue this program and its eligibility requirements, or to terminate assistance, at any time and without prior notice. I understand that assistance depends upon my ability to meet the eligibility criteria for the program. I understand that my personal information shown on this form will not be used for any purpose other than for the FEI Women's Health ParaGard® Patient Assistance Program unless I give written consent, or it is required by the government, or if FEI Women's Health first removes my name and any other identifying information.

Patient's signature _____ Date _____

HEALTHCARE PROFESSIONAL INFORMATION

First name MI Last name

Title

Facility

Street address Suite/Floor

City State Zip code

( ) ( ) Phone Fax

Office contact name

Tax ID#:

Type of Practice: ❑ Public ❑ Private

Number of healthcare professionals in this practice _____

Number of healthcare professionals who place ParaGard® _____

Interested in ParaGard® placement training ❑ Yes ❑ No

Product Distribution Information

ParaGard® will be shipped directly to the healthcare professional's office address at left. A signature is required at time of delivery.

Office hours: _____

Special delivery instructions: _____

Healthcare Professional's Verification and Signature

To the best of my knowledge, this patient does not have insurance coverage (including Medicaid, county-funded assistance, or other public programs) for ParaGard®. No claim may be made to any third party payer for payment of ParaGard® provided by this Patient Assistance Program. The ParaGard® received for this patient may not be sold or traded, may not be returned for credit, and is not a sample. I understand that the FEI Women's Health ParaGard® Patient Assistance Program has the right to modify or discontinue this program and its eligibility requirements, or to terminate assistance, at any time and without prior notice.

Please indicate that you agree to these terms by signing below. Your signature confirms that there is a valid medical need for this patient's prescription for ParaGard®.

Healthcare professional's signature Date

Rx Patient name

Product State license

(If this is your first time ordering from ParaGard Direct, you must submit a copy of your license.)

ARCH FOUNDATION
Access and Resources in Contraceptive Health

ARCH FOUNDATION
PATIENT ASSISTANCE PROGRAM FOR MIRENA®

ARCH Foundation, P.O. Box 220908, Charlotte, NC 28222-0908
Telephone: (877) 393-9071 Fax: (877) 229-1421

Please complete each section to the fullest extent possible. If an item does not apply, please note "N/A" on that line.
Please return this completed confidential application to the above address or fax number.

PROVIDER INFORMATION

Provider Name: _____ MD / NP / Other
Facility Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone Number: (_____) _____
Fax Number: (_____) _____
Contact Person: _____
State License Number: _____
Email Address: _____

Please indicate shipping address if different from above:

Facility Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone Number: (_____) _____
Fax Number: (_____) _____
Contact: _____

Please indicate if your clinical setting is (check all that apply):

- ❑ Title X
- ❑ Planned Parenthood
- ❑ Family Planning Clinic
- ❑ Public Health Clinic (State, City, County)
- ❑ Private Group Practice
- ❑ Private Individual Practice

Hospital

PROVIDER DECLARATION AND AUTHORIZATION

I verify that the information provided in this application is complete and accurate. I verify that, to the best of my knowledge, this patient does not have Medicaid or any other form of insurance or other means to access Mirena®. I understand that the patient must qualify financially and meet the program criteria to be eligible for assistance. I also understand that the ARCH Foundation reserves the right at any time, and without notice, to modify the application form; to modify or discontinue this program and its eligibility criteria; or to terminate assistance. I also understand that the product I receive is not a sample. My signature below confirms that Mirena® will be provided free of charge to this patient as deemed medically appropriate for family planning purposes. I also verify that, to the best of my knowledge, this patient has no insurance coverage for Mirena®.

_____
Provider Signature Date

PATIENT INFORMATION

Patient Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Day Phone: (_____) _____
Evening Phone: (_____) _____

COVERAGE AND INSURANCE

Do you have Medicaid?
❑ YES ❑ NO

Do you have any other form of private or public insurance coverage?
❑ YES ❑ NO

If Yes, please explain why you cannot access Mirena® through that insurance coverage and any steps you have taken to obtain coverage:

_____
_____

FINANCIAL INFORMATION

Current annual household income: $ _____

Number of household members dependent on income stated above (include yourself) _____

APPLICANT DECLARATION AND AUTHORIZATION

I verify that the information provided in this application is complete and accurate. I verify that I do not have Medicaid or any other form of insurance or other means to access Mirena®. I understand assistance depends upon my ability to meet the eligibility criteria for the program. I also understand that the ARCH Foundation reserves the right at any time, and without notice, to modify the application form; to modify or discontinue this program and its eligibility criteria; or to terminate assistance. I authorize my clinician and my insurance company to disclose to the ARCH Foundation and its representatives information about me as deemed necessary to ensure the accuracy and completeness of this application. I understand that any personal information shown on this application will not be used for any purpose other than for the ARCH Foundation unless:

- I give written consent, or
- it is required or permitted under the law, or
- the ARCH Foundation first removes my name and any other identifying information

_____
Patient Signature Date

 web

Perpetual Calendar For LUNELLE

Once-a-Month Dosing Convenience

(Based on dosing intervals of 28 to 30 days. Will need both pages.)

Given	Due	Given	Due	Given	Due	Given	Due
Jan 1	Jan 29 – Jan 31	Feb 19	Mar 19 – Mar 21	Apr 9	May 7 – May 9	May 28	Jun 25 – Jun 27
Jan 2	Jan 30 – Feb 1	Feb 20	Mar 20 – Mar 22	Apr 10	May 8 – May 10	May 29	Jun 26 – Jun 28
Jan 3	Jan 31 – Feb 2	Feb 21	Mar 21 – Mar 23	Apr 11	May 9 – May 11	May 30	Jun 27 – Jun 29
Jan 4	Feb 1 – Feb 3	Feb 22	Mar 22 – Mar 24	Apr 12	May 10 – May 12	May 31	Jun 28 – Jun 30
Jan 5	Feb 2 – Feb 4	Feb 23	Mar 23 – Mar 25	Apr 13	May 11 – May 13	Jun 1	Jun 29 – Jul 1
Jan 6	Feb 3 – Feb 5	Feb 24	Mar 24 – Mar 26	Apr 14	May 12 – May 14	Jun 2	Jun 30 – Jul 2
Jan 7	Feb 4 – Feb 6	Feb 25	Mar 25 – Mar 27	Apr 15	May 13 – May 15	Jun 3	Jul 1 – Ju1 3
Jan 8	Feb 5 – Feb 7	Feb 26	Mar 26 – Mar 28	Apr 16	May 14 – May 16	Jun 4	Jul 2 – Ju1 4
Jan 9	Feb 6 – Feb 8	Feb 27	Mar 27 – Mar 29	Apr 17	May 15 – May 17	Jun 5	Jul 3 – Ju1 5
Jan 10	Feb 7 – Feb 9	Feb 28	Mar 28 – Mar 30	Apr 18	May 16 – May 18	Jun 6	Jul 4 – Ju1 6
Jan 11	Feb 8 – Feb 10	Mar 1	Mar 29 – Mar 31	Apr 19	May 17 – May 19	Jun 7	Jul 5 – Ju1 7
Jan 12	Feb 9 – Feb 11	Mar 2	Mar 30 – Apr 1	Apr 20	May 18 – May 20	Jun 8	Jul 6 – Ju1 8
Jan 13	Feb 10 – Feb 12	Mar 3	Mar 31 – Apr 2	Apr 21	May 19 – May 21	Jun 9	Jul 7 – Ju1 9
Jan 14	Feb 11 – Feb 13	Mar 4	Apr 1 – Apr 3	Apr 22	May 20 – May 22	Jun 10	Jul 8 – Ju1 10
Jan 15	Feb 12 – Feb 14	Mar 5	Apr 2 – Apr 4	Apr 23	May 21 – May 23	Jun 11	Jul 9 – Ju1 11
Jan 16	Feb 13 – Feb 15	Mar 6	Apr 3 – Apr 5	Apr 24	May 22 – May 24	Jun 12	Jul 10 – Ju1 12
Jan 17	Feb 14 – Feb 16	Mar 7	Apr 4 – Apr 6	Apr 25	May 23 – May 25	Jun 13	Jul 11 – Ju1 13
Jan 18	Feb 15 – Feb 17	Mar 8	Apr 5 – Apr 7	Apr 26	May 24 – May 26	Jun 14	Jul 12 – Ju1 14
Jan 19	Feb 16 – Feb 18	Mar 9	Apr 6 – Apr 8	Apr 27	May 25 – May 27	Jun 15	Jul 13 – Ju1 15
Jan 20	Feb 17 – Feb 19	Mar 10	Apr 7 – Apr 9	Apr 28	May 26 – May 28	Jun 16	Jul 14 – Ju1 16
Jan 21	Feb 18 – Feb 20	Mar 11	Apr 8 – Apr 10	Apr 29	May 27 – May 29	Jun 17	Jul 15 – Ju1 17
Jan 22	Feb 19 – Feb 21	Mar 12	Apr 9 – Apr 11	Apr 30	May 28 – May 30	Jun 18	Jul 16 – Ju1 18
Jan 23	Feb 20 – Feb 22	Mar 13	Apr 10 – Apr 12	May 1	May 29 – May 31	Jun 19	Jul 17 – Ju1 19
Jan 24	Feb 21 – Feb 23	Mar 14	Apr 11 – Apr 13	May 2	May 30 – Jun 1	Jun 20	Jul 18 – Ju1 20
Jan 25	Feb 22 – Feb 24	Mar 15	Apr 12 – Apr 14	May 3	May 31 – Jun 2	Jun 21	Jul 19 – Ju1 21
Jan 26	Feb 23 – Feb 25	Mar 16	Apr 13 – Apr 15	May 4	Jun 1 – Jun 3	Jun 22	Jul 20 – Ju1 22
Jan 27	Feb 24 – Feb 26	Mar 17	Apr 14 – Apr 16	May 5	Jun 2 – Jun 4	Jun 23	Jul 21 – Ju1 23
Jan 28	Feb 25 – Feb 27	Mar 18	Apr 15 – Apr 17	May 6	Jun 3 – Jun 5	Jun 24	Jul 22 – Ju1 24
Jan 29	Feb 26 – Feb 28	Mar 19	Apr 16 – Apr 18	May 7	Jun 4 – Jun 6	Jun 25	Jul 23 – Ju1 25
Jan 30	Feb 27 – Mar 1	Mar 20	Apr 17 – Apr 19	May 8	Jun 5 – Jun 7	Jun 26	Jul 24 – Ju1 26
Jan 31	Feb 28 – Mar 2	Mar 21	Apr 18 – Apr 20	May 9	Jun 6 – Jun 8	Jun 27	Jul 25 – Ju1 27
Feb 1	Mar 1 – Mar 3	Mar 22	Apr 19 – Apr 21	May 10	Jun 7 – Jun 9	Jun 28	Jul 26 – Ju1 28
Feb 2	Mar 2 – Mar 4	Mar 23	Apr 20 – Apr 22	May 11	Jun 8 – Jun 10	Jun 29	Jul 27 – Ju1 29
Feb 3	Mar 3 – Mar 5	Mar 24	Apr 21 – Apr 23	May 12	Jun 9 – Jun 11	Jun 30	Jul 28 – Ju1 30
Feb 4	Mar 4 – Mar 6	Mar 25	Apr 22 – Apr 24	May 13	Jun 10 – Jun 12	Jul 1	Jul 29 – Ju1 31
Feb 5	Mar 5 – Mar 7	Mar 26	Apr 23 – Apr 25	May 14	Jun 11 – Jun 13	Jul 2	Jul 30 – Aug 1
Feb 6	Mar 6 – Mar 8	Mar 27	Apr 24 – Apr 26	May 15	Jun 12 – Jun 14	Jul 3	Jul 31 – Aug 2
Feb 7	Mar 7 – Mar 9	Mar 28	Apr 25 – Apr 27	May 16	Jun 13 – Jun 15	Jul 4	Aug 1 – Aug 3
Feb 8	Mar 8 – Mar 10	Mar 29	Apr 26 – Apr 28	May 17	Jun 14 – Jun 16	Jul 5	Aug 2 – Aug 4
Feb 9	Mar 9 – Mar 11	Mar 30	Apr 27 – Apr 29	May 18	Jun 15 – Jun 17	Jul 6	Aug 3 – Aug 5
Feb 10	Mar 10 – Mar 12	Mar 31	Apr 28 – Apr 30	May 19	Jun 16 – Jun 18	Jul 7	Aug 4 – Aug 6
Feb 11	Mar 11 – Mar 13	Apr 1	Apr 29 – May 1	May 20	Jun 17 – Jun 19	Jul 8	Aug 5 – Aug 7
Feb 12	Mar 12 – Mar 14	Apr 2	Apr 30 – May 2	May 21	Jun 18 – Jun 20	Jul 9	Aug 6 – Aug 8
Feb 13	Mar 13 – Mar 15	Apr 3	May 1 – May 3	May 22	Jun 19 – Jun 21	Jul 10	Aug 7 – Aug 9
Feb 14	Mar 14 – Mar 16	Apr 4	May 2 – May 4	May 23	Jun 20 – Jun 22	Jul 11	Aug 8 – Aug 10
Feb 15	Mar 15 – Mar 17	Apr 5	May 3 – May 5	May 24	Jun 21 – Jun 23	Jul 12	Aug 9 – Aug 11
Feb 16	Mar 16 – Mar 18	Apr 6	May 4 – May 6	May 25	Jun 22 – Jun 24	Jul 13	Aug 10 – Aug 12
Feb 17	Mar 17 – Mar 19	Apr 7	May 5 – May 7	May 26	Jun 23 – Jun 25	Jul 14	Aug 11 – Aug 13
Feb 18	Mar 18 – Mar 20	Apr 8	May 6 – May 8	May 27	Jun 24 – Jun 26	Jul 15	Aug 12 – Aug 14

Perpetual Calendar For LUNELLE

Once-a-Month Dosing Convenience

Given	Due	Given	Due	Given	Due	Given	Due
Jul 16	Aug 13 – Aug 15	Aug 28	Sep 25 – Sep 27	Oct 10	Nov 7 – Nov 9	Nov 22	Dec 20 – Dec 22
Jul 17	Aug 14 - Aug 16	Aug 29	Sep 26 – Sep 28	Oct 11	Nov 8 – Nov 10	Nov 23	Dec 21 – Dec 23
Jul 18	Aug 15 - Aug 17	Aug 30	Sep 27 – Sep 29	Oct 12	Nov 9 – Nov 11	Nov 24	Dec 22 – Dec 24
Jul 19	Aug 16 - Aug 18	Aug 31	Sep 28 – Sep 30	Oct 13	Nov 10 – Nov 12	Nov 25	Dec 23 – Dec 25
Jul 20	Aug 17 - Aug 19	Sep 1	Sep 29 – Oct 1	Oct 14	Nov 11 – Nov 13	Nov 26	Dec 24 – Dec 26
Jul 21	Aug 18 - Aug 20	Sep 2	Sep 30 – Oct 2	Oct 15	Nov 12 – Nov 14	Nov 27	Dec 25 – Dec 27
Jul 22	Aug 19 - Aug 21	Sep 3	Oct 1 – Oct 3	Oct 16	Nov 13 – Nov 15	Nov 28	Dec 26 – Dec 28
Jul 23	Aug 20 - Aug 22	Sep 4	Oct 2 – Oct 4	Oct 17	Nov 14 – Nov 16	Nov 29	Dec 27 – Dec 29
Jul 24	Aug 21 - Aug 23	Sep 5	Oct 3 – Oct 5	Oct 18	Nov 15 – Nov 17	Nov 30	Dec 28 – Dec 30
Jul 25	Aug 22 - Aug 24	Sep 6	Oct 4 – Oct 6	Oct 19	Nov 16 – Nov 18	Dec 1	Dec 29 – Dec 31
Jul 26	Aug 23 - Aug 25	Sep 7	Oct 5 – Oct 7	Oct 20	Nov 17 – Nov 19	Dec 2	Dec 30 – Jan 1
Jul 27	Aug 24 - Aug 26	Sep 8	Oct 6 – Oct 8	Oct 21	Nov 18 – Nov 20	Dec 3	Dec 31 – Jan 2
Jul 28	Aug 25 - Aug 27	Sep 9	Oct 7 – Oct 9	Oct 22	Nov 19 – Nov 21	Dec 4	Jan 1 – Jan 3
Jul 29	Aug 26 - Aug 28	Sep 10	Oct 8 – Oct 10	Oct 23	Nov 20 – Nov 22	Dec 5	Jan 2 – Jan 4
Jul 30	Aug 27 - Aug 29	Sep 11	Oct 9 – Oct 11	Oct 24	Nov 21 – Nov 23	Dec 6	Jan 3 – Jan 5
Jul 31	Aug 28 - Aug 30	Sep 12	Oct 10 – Oct 12	Oct 25	Nov 22 – Nov 24	Dec 7	Jan 4 – Jan 6
Aug 1	Aug 29 - Aug 31	Sep 13	Oct 11 – Oct 13	Oct 26	Nov 23 – Nov 25	Dec 8	Jan 5 – Jan 7
Aug 2	Aug 30 – Sep 1	Sep 14	Oct 12 – Oct 14	Oct 27	Nov 24 – Nov 26	Dec 9	Jan 6 – Jan 8
Aug 3	Aug 31 – Sep 2	Sep 15	Oct 13 – Oct 15	Oct 28	Nov 25 – Nov 27	Dec 10	Jan 7 – Jan 9
Aug 4	Sep 1 – Sep 3	Sep 16	Oct 14 – Oct 16	Oct 29	Nov 26 – Nov 28	Dec 11	Jan 8 – Jan 10
Aug 5	Sep 2 – Sep 4	Sep 17	Oct 15 – Oct 17	Oct 30	Nov 27 – Nov 29	Dec 12	Jan 9 – Jan 11
Aug 6	Sep 3 – Sep 5	Sep 18	Oct 16 – Oct 18	Oct 31	Nov 28 – Nov 30	Dec 13	Jan 10 – Jan 12
Aug 7	Sep 4 – Sep 6	Sep 19	Oct 17 – Oct 19	Nov 1	Nov 29 – Dec 1	Dec 14	Jan 11 – Jan 13
Aug 8	Sep 5 – Sep 7	Sep 20	Oct 18 – Oct 20	Nov 2	Nov 30 – Dec 2	Dec 15	Jan 12 – Jan 14
Aug 9	Sep 6 – Sep 8	Sep 21	Oct 19 – Oct 21	Nov 3	Dec 1 – Dec 3	Dec 16	Jan 13 – Jan 15
Aug 10	Sep 7 – Sep 9	Sep 22	Oct 20 – Oct 22	Nov 4	Dec 2 – Dec 4	Dec 17	Jan 14 – Jan 16
Aug 11	Sep 8 – Sep 10	Sep 23	Oct 21 – Oct 23	Nov 5	Dec 3 – Dec 5	Dec 18	Jan 15 – Jan 17
Aug 12	Sep 9 – Sep 11	Sep 24	Oct 22 – Oct 24	Nov 6	Dec 4 – Dec 6	Dec 19	Jan 16 – Jan 18
Aug 13	Sep 10 – Sep 12	Sep 25	Oct 23 – Oct 25	Nov 7	Dec 5 – Dec 7	Dec 20	Jan 17 – Jan 19
Aug 14	Sep 11 – Sep 13	Sep 26	Oct 24 – Oct 26	Nov 8	Dec 6 – Dec 8	Dec 21	Jan 18 – Jan 20
Aug 15	Sep 12 – Sep 14	Sep 27	Oct 25 – Oct 27	Nov 9	Dec 7 – Dec 9	Dec 22	Jan 19 – Jan 21
Aug 16	Sep 13 – Sep 15	Sep 28	Oct 26 – Oct 28	Nov 10	Dec 8 – Dec 10	Dec 23	Jan 20 – Jan 22
Aug 17	Sep 14 – Sep 16	Sep 29	Oct 27 – Oct 29	Nov 11	Dec 9 – Dec 11	Dec 24	Jan 21 – Jan 23
Aug 18	Sep 15 – Sep 17	Sep 30	Oct 28 – Oct 30	Nov 12	Dec 10 – Dec 12	Dec 25	Jan 22 – Jan 24
Aug 19	Sep 16 – Sep 18	Oct 1	Oct 29 – Oct 31	Nov 13	Dec 11 – Dec 13	Dec 26	Jan 23 – Jan 25
Aug 20	Sep 17 – Sep 19	Oct 2	Oct 30 – Nov 1	Nov 14	Dec 12 – Dec 14	Dec 27	Jan 24 – Jan 26
Aug 21	Sep 18 – Sep 20	Oct 3	Oct 31 – Nov 2	Nov 15	Dec 13 – Dec 15	Dec 28	Jan 25 – Jan 27
Aug 22	Sep 19 – Sep 21	Oct 4	Nov 1 – Nov 3	Nov 16	Dec 14 – Dec 16	Dec 29	Jan 26 – Jan 28
Aug 23	Sep 20 – Sep 22	Oct 5	Nov 2 – Nov 4	Nov 17	Dec 15 – Dec 17	Dec 30	Jan 27 – Jan 29
Aug 24	Sep 21 – Sep 23	Oct 6	Nov 3 – Nov 5	Nov 18	Dec 16 – Dec 18	Dec 31	Jan 28 – Jan 30
Aug 25	Sep 22 – Sep 24	Oct 7	Nov 4 – Nov 6	Nov 19	Dec 17 – Dec 19		
Aug 26	Sep 23 – Sep 25	Oct 8	Nov 5 – Nov 7	Nov 20	Dec 18 – Dec 20		
Aug 27	Sep 24 – Sep 26	Oct 9	Nov 6 – Nov 8	Nov 21	Dec 19 – Dec 21		

Last updated: 09/24/02

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Family Planning Medical Director Consultation Contact Information

TO: Supervisors/Providers
FROM: Leslie Miller, MD
SUBJECT: Provider Evaluation Requests or other contact needs

1) Contact numbers for Dr. Miller

Phone:	206-731-3228 (voice mail) or 206-731-3319 (office)
Fax:	206-731-5249
Harborview:	206-731-3367
e-mail:	lmiller@u.washington.edu
Pager:	206-995-1871
Web page:	http://www.noperiod.com
Calendar:	http://calendar.yahoo.com/noperiod

Mailing Address:
Harborview Medical Center
Obstetrics & Gynecology
Box 359865
325 Ninth Avenue
Seattle, WA 98104-2499

2) Contact numbers for Dr. Hitti / Obstetrical Consultations

Phone:	206-543-9867
Fax:	206-616-9479
e-mail:	jhitti@u.washington.edu
Pager:	206-991-4968

3) Paging Tips

If paged and no response, put the number in a second time as it may have been entered incorrectly and we cannot guess the correct number.

If a true emergency, page a second time or try it with a 911 after your number. Otherwise, it may take time to respond, especially when we are in clinic or OR. We generally answer voice mail and e-mail twice a day.

4) Other Resources

Harborview has a third-year gynecology resident on call at all times who can be reached by paging 206-731-3000 and having the operator page the gynecology resident on call, or if between 8am – 4pm, you could speak with the Women's Clinic Triage Nurse at 206-731-8596 or 206-731-2490. There are also resident physicians on Labor and Delivery 24 hours a day who can be reached at 206-598-4617 or 206-598-4616 or at HMC at 206-731-4655.

5) HMC Referrals

Harborview Women's Clinic Patient Care Coordinator is Cathy Craig, 206-731-8597 to schedule surgical consults/BTL/LEEP/preop/surgery visits and to track down records/follow-up if needed. Please send referral requests to fax number (206-731-8038). Breast Clinic Referrals, contact Katherine Vetter (206-731-3261, voice mail, or 206-731-8038, fax).

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Harborview Medical Center Payment Options

Information About Insurance And Other Funding

The following is a listing of options available to help you pay for your bill. Each section explains how you can find out more information about that option.

Private Insurance Coverage

Includes coverage by companies such as Premera Blue Cross, Regence Blue Shield, Aetna US Healthcare. Usually available through your employer or as a private contract with an insurance company. Check with your employer or contact an insurance company directly for information about coverage.

Medicare

For people over 65 years of age and disabled people of any age. Obtained from the federal government through the Social Security Administration. For general Medicare questions, contact your local Social Security office or call the Social Security Teleservice Center at 1-800-772-1213. A number of insurance companies also offer Medicare supplemental insurance. For additional assistance with senior health insurance options, call the Statewide Health Insurance Benefits Advisors (SHIBA) at 1-800-397-4422.

Medicaid

For people with limited income or resources. Obtained from the State of Washington (or the state where you live). In addition, people over the age of 65, disabled people, and people with long-term problems may also qualify. There are also special programs for women and children. If you were admitted to Harborview in the last 30 days, call our Health Coverage Services Department (HCSD) at (206) 731-3084 or got o Room GEH-49. If you are seen in one of our clinics, call HCSD at (206) 731-3021 or go to Room GWH-11, off the main lobby.

Basic Health Plan (BHP)

Open to Washington residents and managed by the state. Monthly premiums are based on your income. For general information about the Basic Health Plan, call 1-800-826-2444. For help enrolling and choosing a Harborview Medical Center physician as your provider, please contact our Health Coverage Services Department (HCSD) at (206) 731-5900 or go to Room GWH-11.

Low Income Allowance (LIA)

Short-term program offered by Harborview Medical Center while your application for other coverage is pending. This program is for people with little or no income. To see if this option is open to you, check with a Patient Registration Representative while registering, or call (206) 731-5930.

Labor and Industries

If you are injured on the job, please tell the Patient Registration Representative and he or she will start a claim for you. This claim is your right as an employee. For more information, please contact the Department of Labor and Industries at 1-800-LISTENS (1-800-547-8367).

Crime Victims Compensation

For victims of crimes or domestic disputes. Application forms are available in the Harborview Medical Center Emergency Department. For help, contact your local Victim/Witness Assistance Unit, located in the Prosecuting Attorney's office, or call the Crime Victims Compensation Program at (206) 956-5355 or 1-800-762-3716.

Charity/Special Payment Plans

If you have a bill that you cannot afford to pay and would like to see if you can receive charity; or if you want to set up a special payment plan, contact Harborview's Patient Financial Relations Office at (206) 731-3554, or the Medical Center's Collections Department at (206) 543-4540. Ask for a Confidential Financial Information Form and instruction sheet. After the completed form is received and reviewed, a Collection Department representative will contact you to talk about a payment plan.

GETTING THE FINANCIAL INFORMATION YOU NEED

I have no insurance. What financial programs are available?

Patient Financial Relations
Room 1EH-153
(206) 731-3554

I want to apply for state assistance or the Washington Basic Health Plan (BHP).

Inpatient: Health Coverage Services – Inpatient Office
Room GEH 49
(206) 731-3084

Outpatient: Health Coverage Services – Outpatient Office
GWH – 11
(206) 731-3021

Basic Health Plan: Health Coverage Services – BHP Office
GWH – 11
(206) 731-5900

I have a Harborview bill and cannot pay it right now.

Hospital Bill: Patient financial Services
(206) 543-4540

or

Patient Financial Relations
Room 1EH – 153
(206) 731-3554

Physician Bill: University of Washington Physicians (UWP)
(206) 543-8606

or

UWP Financial Counseling at Harborview Medical Center
Room 1EH – 150
(206) 731-3087

What will my insurance pay on my bill?

Please contact your insurance company's customer service department or your employer's benefits office. Many employers offer their employees a benefits brochure. Call the number in your benefits brochure or the phone number listed on your insurance card.

Last updated: 8/27/03

IMPORTANT INFORMATION ABOUT YOUR REFERRAL TO HARBORVIEW MEDICAL CENTER

325 9th Ave, Seattle WA 98104
206-731-3000

1) **First,** call outpatient registration at (206) 731-3124, 731-8845 or 731-5930, and if an interpreter is needed, call (206) 731-2384 and say that you need to register as a patient. You will be given a temporary hospital number. If you do not have medical coupons (from DSHS) or insurance and you are worried about paying your bill, you must state your need for financial assistance at the time of registration. If you are going to the Emergency Room or Urgent Care Clinic, you still must register at the registration desk when you arrive.
2) **Second,** ask to be connected to the clinic you have been referred to so you can make your appointment. You can also call directly:

Emergency Room (no appt. needed)	206-731-3074
Urgent Care Clinic	206-731-5867
	Fax 206-521-1915
Radiology	206-731-3105
	Fax 206-731-8206
Women's Clinic	206-731-3367
	Fax 206-731-6312
Medical Records	206-521-1573
Eye Clinic	206-731-3225
	Fax 206-731-8520

3W Clinics:
731-3241, Fax 731-4860

- Dermatology
- Endoscopy/GI
- Allergy
- Arthritis/Autoimmune
- Pulmonary/Thoracic
- Endocrine (diabetes/thyroid)
- Vascular
- Heme/Onc/Thrombosis
- Urology
- General Surgery

4W Clinics:
206-731-3475, Fax 731-8527

- Cardiology
- Neurology

2W Clinics:

- Infectious Disease
  HIV/NW Family Center
  206-731-5100, Fax 731-5109
- Hepatitis/Liver Clinic
  206-731-6475, Fax 731-5515

6E Clinics:
206-731-3462 (#0, #1), 731-4830

- Orthopedics
- Podiatry

3) **On the day of your appointment,** stop by the ground floor south registration desk to pick up your Harborview card. If you did not register by phone ahead of time, you will need to arrive 45 minutes before your appointment to register. Remember, give yourself plenty of time to park. There is a patient parking lot west of the hospital on Alder St. Bring the parking stub to the clinic for validation, but it will still cost 4 to 6 dollars. If you park illegally, your car will be towed.
4) If you are being referred for colposcopy or gynecology, contact Cathy Craig at 206-731-8597. For the Breast Clinic, Katherine Vetter at 206-731-3261 to help make the arrangements. For sterilization or gynecologic surgery, contact Penny Brooks at 206-731-3373.

IMPORTANT! At each visit you must tell registration about your need for financial assistance!

Your appointment is scheduled for:

Date: _____

Time:_____

(Give yourself plenty of time to find parking.)

Harborview Medical Center Directions:

- Harborview is located on the comer of Ninth Avenue and Jefferson Street.
- Take the James Street exit off I-5 in the downtown area of Seattle.
- Turn up the hill (east) on James Street and go to Ninth Avenue.
- Turn right (south) on Ninth Avenue and go one block.

Specialty referrals for clients at PHSKC non-primary care sites

Within this document, you will find breast care resources for routine diagnostic needs. Any non-routine medical services and/or referrals to specialty care are to be coordinated by a primary care physician.

- If you have a client that you suspect may have a serious condition (breast mass, abnormal pap, abdominal mass, etc.) counsel the client to return to her primary care physician for coordination of care (including specialty care referral). Document that you counseled client on the need to see her primary care provider. Fax all pertinent chart notes and diagnostic testing results (if applicable) to the primary care physician. Keep copy of fax in chart.

- If the client has not established care with a primary care physician and wishes to obtain one, the client can be referred to one of PHSKC's primary care sites or to CHAP at 1-800-756-5437. The client services specialist can assist with this. Once you have the name of the client's primary care provider, fax all pertinent chart notes and diagnostic testing results (if applicable) to the new primary care physician. Keep copy of fax in chart.

- If the client is age 40-64 and of limited financial resources, she may qualify for services through the Breast and Cervical Health Program at 1-800-756-5437.

- An additional resource is the Harborview Breast Clinic at 206-731-3261 – fax is 206-731-8038. The Patient Care Coordinator at the Clinic is Catherine Vetter at 206-731-3261.

BREAST CARE RESOURCES (Mammography, Ultrasound, etc.)

Here are some resources for your clients who do not qualify for the Breast & Cervical Health Program (under 40 years old) and who are uninsured or underinsured (as with Basic Health Plan). All of the Swedish affiliated centers below provide charity care (the client must fill out Swedish's charity care application and provide the required documentation).

If the client is insured, she can utilize the breast care providers contracted with her health plan. These same breast care centers take most insurances.

Swedish Breast Care Centers

The Swedish Breast Care Centers network is equipped with the latest technologies and offers a wide range of state-of-the-art screening and diagnostic capabilities, including:

- Mammography
- Ultrasound
- Fine needle aspirate
- Cyst aspirations

- Stereotactic and ultrasound-guided core biopsy
- Preoperative needle localization of nonpalpable suspicious lesions
- Sentinel node mapping
- Breast self-examination instruction

Swedish Breast Care Center
First Hill Campus
1101 Madison St., Suite 310
Seattle, WA 98104
(206) 386-3776
Hours: 8 a.m.-5 p.m., Monday-Friday

Women's Diagnostic Imaging Center
First Hill Campus
1221 Madison St., Suite 520
Seattle, WA 98104
(206) 215-3939
Hours: 8 a.m.-4:30 p.m., Monday-Friday

Comprehensive Breast Center
Providence Campus
1600 E. Jefferson St., Suite 300
Seattle, WA 98122
(206) 320-4800
Hours: 8 a.m.-5:30 p.m., Monday-Friday

Women's Imaging Center
Ballard Campus
5300 Tallman Ave. N.W.
2nd Floor Women's Imaging
Seattle, WA 98107
(206) 781-6349
Hours: 7:30 a.m.-5 p.m., Monday-Friday

TERMINATION OF PREGNANCY REFERRAL INFORMATON

Pregnancy Confirmation

Date Seen at:_____ Urine HCG Positive: ❑ LMP: _____ EGA Today: _____

Planned method of Contraception after termination: _____

Clinic Provider:

_____

_____

_____

Instructions If Planning Termination of Pregnancy:

1. Call to schedule an appointment.
2. Bathe or shower before your appointment time.
3. Bring 2 sanitary napkins (pads) with you.
4. Do not have anything to eat or drink 2 hours before the appointment and do not drink any alcohol or use any street drugs 24 hours before your appointment.
5. The procedure is relatively painless and is done under local anesthetic. Sedative or additional pain medication optional.
6. Bring cash, money order, VISA or Master Card for payment. Most clinics do not accept personal checks. Most clinics do accept medical coupons (bring your current coupon to the appointment) and some insurance with pre-approval
7. Plan to spend 2 to 4 hours in the clinic.
8. You must have someone to drive you home if you receive a sedative or pain medication.
9. No infants or children are permitted in the waiting room.
10. If you are having a 2 to 3 day procedure, you must stay overnight within 30 minutes of the clinic.

Referral from clinic below:

Provider name: _____

- ❑ **Auburn Public Health Center (206) 296-8400**
  20 Auburn Ave., Auburn, WA 98002
- ❑ **Columbia Public Health Center (206) 296-4650**
  4400-37th Ave. So., Seattle, WA 98118
- ❑ **Downtown Public Health Center (206) 296-4755**
  2124-4th Ave., Seattle, WA 98121
- ❑ **Eastgate Public Health Center (206) 296-4920**
  14350 S.E. Eastgate Way, Bellevue, WA 98007
- ❑ **Federal Way Public Health Center (206) 296-8410**
  33431 13th Place So., Federal Way, WA 98003
- ❑ **Kent Public Health Center (206) 296-4500**
  1404 S. Central Ave. Suite #112, Kent, WA 98032
- ❑ **Kent Teen Clinic (206) 296-7450**
  613 W. Gowe, Kent, WA 98032
- ❑ **North Public Health Center (206) 296-4765**
  10501 Meridian Ave. North, Seattle, WA 98133
- ❑ **Northshore Public Health Center (206) 296-9787**
  10808 N.E. 145th Street, Bothell, WA 98011
- ❑ **Renton Public Health Center (206) 296-4700**
  3001 N.E. 4th, Renton, WA 98056
- ❑ **White Center Public Health Center (206) 296-4620**
  10821-8th Ave. S.W., Seattle, WA 98146
- ❑ **Other:** _____

_____

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Place Patient Information Sticker Here
OR Name & DOB

Public Health
Seattle & King County

HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Alonzo L. Plough, Ph.D., MPH, *Director*

AUTHORIZATION FOR STATE FUNDED SURGICAL SERVICES

TO: _____ _____
Physician Date

FROM: _____ _____
Public Health Family Planning Clinic Phone

RE: Referral for Surgical Procedure, Reimbursed by State Funded Services

_____ _____
Client Name Date of Birth

_____ _____
Client ID# Zip Code

The above client has been seen at our clinic and is financially eligible to receive the following state funded surgical service: (circled)

Pregnancy Termination Tubal Ligation Vasectomy

This authorization expires: _____
Date (180 days from date signed)

Please send all billing to: Public Health - Seattle & King County
Accounting Services Department
999 3rd Ave., Suite 600
Seattle, WA 98104

Please note:
1. Do not bill the patient directly for services provided.
2. Payment for services is determined case-by-case by Dept of Health, typically Medicaid reimbursement rates.
3. Federal regulation stipulates that patients seeking sterilization must wait 31 days from the day of consent (obtained during counseling at our clinic) to the day of the surgery. See attached consent form. If this regulation is not followed, payment may be denied.

Should hospitalization and or anesthesiology be required for this patient, please inform the facility and or anesthesiologist of these billing procedures. Prompt billing within 30 days of the service is appreciated.

1 copy to client 1 copy to accounting services 1 copy to medical record

h:\forms\surgical services authorization (7/04)

STERILIZATION CONSENT FORM

NOTE: Your decision at any time not to be sterilized will not result in the withdrawal or withholding of any benefits provided by programs or projects receiving Federal funds.

SECTION I: CONSENT TO STERILIZATION

I have asked for and received information about sterilization from

(1) _____
Physician or Clinic

When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized . If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Aid to Families with Dependent Children (AFDC) or Medicaid, that I am now getting or for which I may become eligible.

I understand that the sterilization must be considered permanent and not reversible. I have decided that I do not want to become pregnant, bear children, or father children.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized. I understand that I will be sterilized by an operation known as a

(2) _____ The discomforts, risks, and
Specify type of operation

benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty (30) days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by Federally-funded programs.

I am at least 21 years of age and was born on (3) _____
Month Day Year

I (4) _____ hereby consent of my own
Individual to be sterilized

free will to be sterilized by (5) _____
Physician

by a method called (6) _____ My consent
Specify type of operation

expires 180 days from the date of my signature below.
I also consent to the release of this form and other medical records about the operation to:

- Representatives of the Department of Health and Human Services; or
- Employees of programs or projects funded by that department but only for determining if Federal laws were observed.

I have received a copy of this form.

(7) _____ (8) _____
Signature *Month Day Year*

You are requested to supply the following information, but it is not required.
Race and ethnicity designation (please check):

- ☐ American Indian or Alaska Native
- ☐ Asian or Pacific Islander
- ☐ Black (not of Hispanic origin)
- ☐ Hispanic
- ☐ White (not of Hispanic origin)

SECTION II: INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized: I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the

consent form in (9) _____ language and explained
Language

its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

(10) _____ (11) _____
Interpreter *Date*

SECTION III: STATEMENT OF PERSON OBTAINING CONSENT

Before (12) _____ signed the consent form, I
Name of individual

explained to him/her the nature of the sterilization operation,

(13) _____ the fact that it is intended to be
Specify type of operation

a final and irreversible procedure; and the discomforts, risks, and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief, the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

(14) _____ (15) _____
Signature of person obtaining consent *Date*

(16) _____
Facility

(17) _____
Address

SECTION IV: PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon

(18) _____ (19) _____
Name of individual to be sterilized *Date of sterilization operation*

I explained to him/her the nature of the sterilization operation

(20) _____ The fact that it is intended to be
Specify type of operation

a final and irreversible procedure; and the discomforts, risks, and benefits associated with it. I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds. To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less that 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty (30) days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than thirty (30) days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested.)

- ☐ Premature delivery
  Individual's expected date of delivery (21) _____
- ☐ Emergency abdominal surgery (describe circumstances)

(22) _____ (23) _____
Physician's Signature *Date*

(24) _____
Physician's Printed Name

Washington State DEPARTMENT OF SOCIAL & HEALTH SERVICES

STERILIZATION CONSENT FORM
FORMULARIO DE PERMISO PARA ESTERILIZACIÓN

NOTA: Si en cualquier momento decide no hacerse esterilizar, no se le retirará ni retendrá ningún beneficio proporcionado por programas o proyectos que reciben financiamiento federal.

SECCIÓN I: PERMISO PARA ESTERILIZACIÓN

He solicitado y he recibido información sobre esterilización por parte de

(1) _____
(Médico o clínica)

Cuando pedí la información inicialmente, me dijeron que la decisión sobre hacerme esterilizar o no era únicamente mía. Me dijeron que yo podía decidir no hacerme esterilizar. Si decido no hacerme esterilizar, mi decisión no afectará mi derecho de recibir tratamiento o atención en el futuro. No perderé ninguna asistencia ni beneficio de los programas que reciben financiamiento federal, por ejemplo Asistencia para Familias con Niños Dependientes (AFDC) o Medicaid, que estoy recibiendo ahora o tengo derecho a recibir.

Entiendo que la esterización se debe considerar como permanente e irreversible. He decidido que no deseo quedar embarazada, dar a luz o ser madre/padre de niños.

Me informaron sobre los métodos temporales de control de la natalidad que se encuentran disponibles y que me pueden proporcionar los cuales me permitirán dar a luz o ser madre/padre de un niño en el futuro. He rechazado esas alternativas y he decidido hacerme esterilizar. Entiendo que me esterilizarán a través de una operación que se conoce como

(2) _____ Me han explicado cuáles
(Especifique el tipo de operación)

serían los malestares, riesgos y beneficios asociados con la operación. Han respondido a todas mis preguntas a mi entera satisfacción.

Entiendo que la operación se efectuará por lo menos treinta (30) días después de que yo firme este formulario. Entiendo que puedo cambiar de opinión en cualquier momento y que mi decisión de no hacerme esterilizar en cualquier momento, no dará como consecuencia la retención de ningún beneficio ni servicio médico que proporcionan los programas con financiamiento federal.

Tengo por lo menos 21 años de edad y nací en fecha (3) _____
(Mes, Día, Año)

Por el presente documento, yo (4) _____
(La persona que se hará esterilizar)

doy mi permiso por mi propia y libre voluntad para ser esterilizado/a por

(5) _____ a través de un
(Médico)

método denominado (6) _____
(Especifique el tipo de operación)

Mi consentimiento expira 180 días después de la fecha de mi firma abajo. También doy mi permiso para revelar este formulario y otros registros médicos sobre la operación a:

- Representantes del Departamento de Salud y Servicios Humanos; o
- Funcionarios de programas o proyectos financiados por el Departamento, pero sólo con el propósito de determinar si se cumplieron las leyes federales.

He recibido una copia de este formulario.

(7) _____ (8) _____
Firma *Mes Día Año*

Por favor proporcione la siguiente información, pero no es obligatoria.
Designación de raza y origen étnico (por favor marque):

- ☐ Indio nativoamericano o de Alaska
- ☐ Asiático o de las Islas del Pacífico
- ☐ Negro (no de origen hispano)
- ☐ Hispano
- ☐ Blanco (no de origen hispano)

SECCIÓN II: DECLARACIÓN DEL INTÉRPRETE

Si se proporcionaron los servicios de un intérprete para ayudar a la persona que va a ser esterilizada: He traducido la información y los consejos que proporcionó en forma oral la persona que está obteniendo este consentimiento para la persona que se hará esterilizar. También he leído para esta persona el formulario de permiso en

(9) _____ y le he explicado su contenido.
(Idioma)

Según lo mejor de mis conocimientos y convicción, él/ella ha entendido esta explicación.

(10) _____ (11) _____
Intérprete *Fecha*

SECCIÓN III: DECLARACIÓN DE LA PERSONA QUE ESTÁ OBTENIENDO EL CONSENTIMIENTO

Antes de que (12) _____ firme este formulario
(Nombre de la persona)

de permiso, le expliqué la naturaleza de la operación de esterilización

(13) _____ el hecho de que será un procedimiento
(Especifique el tipo de operación)

final e irreversible y los malestares, riesgos y beneficios asociados con la misma.

He orientado a la persona que se hará esterilizar sobre otros métodos alternativos de control de la natalidad disponibles que son temporales. Le he explicado que la esterilización es diferente porque es permanente.

He informado a la persona que se hará esterilizar que puede revocar su consentimiento en cualquier momento y que él/ella no perderá ningún servicio ni beneficio de salud proporcionado con financiamiento federal.

Según lo mejor de mis conocimientos y convicción, la persona que se hará esterilizar tiene por lo menos 21 años de edad y parece mentalmente competente. Él/ella solicitó a sabiendas y en forma voluntaria ser esterilizado/a y parece entender la naturaleza y las consecuencias del procedimiento.

(14) _____ (15) _____
Firma de la persona que obtendrá el consentimiento *Fecha*

(16) _____
Establecimiento

(17) _____
Dirección

SECCIÓN IV: DECLARACIÓN DEL MÉDICO

Poco antes de que yo realizara una operación de esterilización a

(18) _____ (19) _____
(Nombre de la persona que se hará esterilizar) *(Fecha de la operación de esterilización)*

yo le expliqué la naturaleza de la operación de esterilización

(20) _____ el hecho de que será un
(Especifique el tipo de operación)

procedimiento final e irreversible y los malestares, riesgos y beneficios asociados con el mismo. Yo le dí orientación a la persona que se hará esterilizar sobre otros métodos de control de la natalidad que son temporales. Le expliqué que la esterilización es diferente porque es permanente. Le informé a la persona que se hará esterilizar que se puede revocar su permiso en cualquier momento y que él/ella no perderá ningún servicio ni beneficio de salud que se proporciona con fondos federales. Según lo mejor de mis conocimientos y creencias, la persona que se hará esterilizar tiene por lo menos 21años de edad y parece mentalmente competente. Él/ella solicitó en forma voluntaria y a sabiendas ser esterilizado/a y parece entender la naturaleza y las consecuencias del procedimiento.

(Instrucciones para utilizar otros párrafos finales: Utilice el primer párrafo de abajo, salvo en el caso de un parto prematuro o una cirugía abdominal de emergencia donde se realice la esterilización menos de 30 días después de la fecha de la firma de la persona que aparece en el formulario de permiso. En esos casos, se debe utilizar el segundo párrafo. Tache el párrafo que no se utilice).

(1) Han transcurrido por lo menos treinta (30) días entre la fecha de la firma de la persona que aparece en este formulario de permiso y la fecha en que se realizó la esterilización.

(2) Esta esterilización se realizó menos de treinta (30) días pero más de 72 horas después de la fecha de la firma de la persona que aparece en este formulario de permiso, debido a las siguientes circunstancias (marque el recuadro aplicable y llene la información que se solicita).

☐ Parto prematuro
Fecha prevista del parto de la persona (21) _____

☐ Cirugía abdominal de emergencia (describa las circunstancias)

(22) _____ (23) _____
Firma del médico *Fecha*

(24) _____
Nombre del médico en letra de imprenta

Washington State DEPARTMENT OF SOCIAL & HEALTH SERVICES

FORMULARIO DE DECLARACION DEL CLIENTE

NOTA: Si en cualquier momento decide no hacerse esterilizar, no se le retirará ni retendrá ningún beneficio proporcionado por programas o proyectos que reciben financiamiento federal.

DECLARACION DEL CLIENTE

Por el presente documento, yo (1) _____ doy mi permiso por mi propia y libre voluntad
(La persona que se hará esterilizar)

para ser esterilizado/a por (2) _____ a través de un método denominado
(Médico)

(3) _____ . Mi consentimiento expira 180 días después de la fecha de mi firma abajo.
(Especifique el tipo de operación)

Asimismo, doy mi permiso para revelar este formulario y otros registros médicos sobre la operación a:

- Representantes del Departamento de Salud y Servicios Humanos; o
- Funcionarios de programas o proyectos financiados por el Departamento, pero sólo con el propósito de determinar si se cumplieron las leyes federales.

He recibido una copia de este formulario.

(4) _____ (5) _____
Firma *Mes Día Año*

Por favor proporcione la siguiente información, pero no es obligatoria. *Designación de raza y origen étnico (por favor marque):*

☐ Indio nativoamericano o de Alaska ☐ Negro (no de origen hispano) ☐ Blanco (no de origen hispano)

☐ Asiático o de las Islas del Pacífico ☐ Hispano

DECLARACIÓN DEL INTÉRPRETE (Para ser utilizada si se proporcionan los servicios de un intérprete para ayudar a la persona que va a ser esterilizada)

He traducido la información y los consejos que proporcionó en forma oral la persona que está obteniendo este consentimiento para la persona que se hará esterilizar. También he leído para esta persona el formulario de permiso en _____ y le he explicado su contenido. Según lo mejor de mis conocimientos y convicción, él/ella ha entendido esta explicación.
(Idioma)

_____ _____
Intérprete *Fecha*

Using Family Planning State-Funded Surgical Services Funds

Background:
As part of our Family Planning Grant from the Washington State Department of Health, we receive approximately $30,000 of State funds to pay for tubals, vasectomies, and abortions for clients who do not have any type of third party insurance. We refer eligible clients to providers in the community, the community provider bills PHSKC for the funds, and the claim gets paid.

We rarely spend this allotment, so it is likely that funds will be available through the end of the calendar year. Please call Maria Wood, Family Planning Program Manager, 206-296-4879, to check on availability of funds, or to discuss unusual circumstances.

Process:
Listed below are the steps and paperwork required to access State Surgical Services funds for clients. All forms referenced and underlined below are posted on the Family Planning web site in the FP Guidelines/Resources/Surgical Services section.

1. Using income and family size information on the current version of the Surgical Services Eligibility Form, determine whether the client is income-eligible to receive the procedure with State Surgical Services funds.

2. If the client is eligible, assist the client to fill out the form completely, including questions about current or past TANF grant information. The client and the witness sign the form. Routing: original to client's medical record; and one copy to Noi Yesuwan, Accounting Services, WFC 600 PH.

3. Complete the Authorization for State-Funded Surgical Services referral letter. Make two copies of the completed form. Routing: original to client's medical record; one copy with the client to the provider who will be doing the procedure; and final copy to Noi Yesuwan, Accounting Services, WFC 600 PH.

For tubals or vasectomies:

4. The client needs to fill out and sign the Sterilization Consent Form (form #13-364 (REV. 02/20/2002)), available in both English and Spanish. There is a 30-day waiting period required for sterilizations which means that the form needs to be signed at least 31 days prior to the procedure. For example, if signed on 2/4/04, the first eligible date the procedure could be completed on is 3/7/04. Some community providers prefer to do the sterilization counseling and consent themselves.

5. Make two copies of the completed form. Routing: original to client's medical record; one copy with the client to the provider who will be doing the procedure; and final copy to Noi Yesuwan, Accounting Services, WFC 600 PH.

6. Review community provider options. See Referral List: Female Sterilization and Referral List: Vasectomy on the FP web site.

7. Instruct clients to take copies of the Authorization for State-Funded Surgical Services and Sterilization Consent Form to their appointment for the procedure.

For abortions:

8. Review community provider options. See Abortion Referral on the FP web site.

9. Fill out the Abortion Referral and make one copy. Routing: original to client's medical record; copy with the client to the provider who will be doing the procedure.

10. Instruct clients to take copies of the Authorization for State-Funded Surgical Services and the Abortion Referral to their appointment for the procedure.

Paperwork Routing Summary:

For tubals and vasectomies:

Document	**Chart**	**Client/Community Provider**	**Accounting Services**
Surgical Services Eligibility Form	**X**		**X**
Authorization for State-Funded Surgical Services	**X**	**X**	**X**
Sterilization Consent Form	**X**	**X**	**X**

For abortions:

Document	**Chart**	**Client/Community Provider**	**Accounting Services**
Surgical Services Eligibility Form	**X**		**X**
Authorization for State-Funded Surgical Services	**X**	**X**	**X**
Abortion Referral	**X**	**X**	

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Sterilization Take Charge Referral Instructions

- Client is determined eligible for Take Charge and completes application.
- Eligiblity for Take Charge is confirmed via electronic eligibility system.
- Client requests vasectomy or tubal ligation referral.
- Clinic staff provides list of surgical providers in the community who serve Medicaid clients, and/or facilitates setting up appointment.
- Completes referral paperwork, including Release of Information as needed.
- Give client a copy of Take Charge **billing instructions letter** to take to the surgical appointment.
- Surgical provider can bill for complete process including pre-procedure counseling and consent process, and post-vasectomy sperm count.

200% FPL

FAMILY PLANNING AND REPRODUCTIVE HEALTH
DETERMINATION OF CLIENT ELIGIBILITY FOR STATE FUNDED SURGICAL SERVICES
Effective April 1, 2005

Client Name _____ Client ID Number _____

Date of Visit _____ Date of Birth _____ Age _____

Gross Monthly Income _____ Family Size _____

Family Size	1	2	3	4	5	6	7	8	Each Additional Person
Maximum* Monthly Income	**$1,596**	**$2,138**	**$2,682**	**$3,226**	**$3,768**	**$4,312**	**$4,856**	**$5,398**	**$271**

SERVICE CLIENT IS ELIGIBLE FOR _____

FROM _____ **TO** _____

"I am not covered by a private insurance or Title XIX (Public Assistance) plan which covers this service."
"I have been offered a written statement of the results of this eligibility determination."
"I hereby agree that all facts stated above are true and accurate to the best of my knowledge."

_____ _____
Client's Signature Date Witness' Signature Date

CLIENT ELIGIBILITY DETERMINATION FOR NEW SERVICE WHEN FAMILY SIZE AND INCOME HAVE NOT CHANGED

SERVICE CLIENT IS ELIGIBLE FOR _____

ELIGIBILITY PERIOD FROM _____ **TO** _____

"My family size and income have not changed since the last eligibility determination."

_____ _____
Client's Signature Date Witness' Signature Date

Eligibility for state funded services does not guarantee/ensure that services will be provided with those funds. Provision of service with state funds is dependent upon availability of funds.

*** Instructions for computing monthly income and completing this form are on the back.**

Revised :3/18/05

INSTRUCTIONS FOR COMPUTING INCOME AND COMPLETING THE CLIENT ELIGIBILITY CONSENT FORM

COMPLETE TOP HALF OF THIS FORM WHEN:

1. Client makes first visit to clinic to seek state funded surgical services.

2. Client has already had an eligibility determination completed, returns for another type of service, and either his/her family size or income has changed since the last eligibility determination. (When another type of service is requested, the client must be redetermined eligible for subsidized services regardless of when the last eligibility determination was completed).

COMPLETE BOTTOM HALF OF THIS FORM WHEN:

1. Client has already had an eligibility determination completed, returns for another type of service, and neither his/her family size nor income have changed since the last eligibility determination.

HOW TO COMPLETE THIS FORM:

CLIENT NAME:	Print client's name.
CLIENT NUMBER:	Enter client's assigned identification/ID number.
DATE OF VISIT:	Enter six digit date of visit e.g., month/day/year.
DATE OF BIRTH:	Enter six digit date of birth e.g., month/day/year (04/21/80).
AGE:	Enter client's age.
GROSS MONTHLY INCOME AND FAMILY SIZE:	Enter gross monthly income and total number of family members supported by client's gross monthly income. For a definition of family and gross monthly income see FPRH Policy 4500 – Client Fees
HOW TO COMPUTE MONTHLY INCOME:	Divide yearly/annual income by 12, or multiply weekly income by 4.33, or multiply hourly income by 173.
SERVICE CLIENT IS ELIGIBLE FOR:	Write in type of state funded surgical service the client desires.
ELIGIBILITY PERIOD:	Write in beginning and ending dates of eligibility. The length of eligibility for surgical services is six months from the date of determination, e.g., from April 21, 2004 through October 20, 2004.
CLIENT'S SIGNATURE:	Obtain the client's signature and have him/her date it. If the client is incompetent or incapacitated, a person acting responsibly for him/her may sign and date the form. This includes agency staff. Unless a signature and date are obtained, the eligibility determination is not valid.
WITNESS SIGNATURE:	An agency staff person must sign and date the form **AFTER** observing the client signs and dates the form.

djc: Revised: 10/27/2005

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Alonzo L. Plough, Ph.D., MPH, *Director*

RE: IMPORTANT BILLING INSTRUCTIONS

Dear Surgical Provider,

The following patient, _____, is being referred to you for a surgical procedure. This client has coverage for the procedure through a Medicaid program called Take Charge that covers Family Planning services for low-income women and men. Covered surgical procedures include vasectomy and tubal ligation.

In order for the pre-sterilization consent visit and procedure to be covered, the following information should be included on the billing statement:

- V25.2 must be used as the primary diagnosis
- The Family Planning Provider number for the Take Charge Provider who has referred the patient must be entered in box 17A of the HCFA 1500 claim form. Our provider number is **7900335**.
- For the pre-sterilization visit, please write "signing sterilization consent form" on the claim, or if billing electronically, enter it in the comments field.

If you have any questions about this coverage, you can call the Washington State Medical Assistance Administration Family Planning line at 1-800-770-4334 for further information.

Thank you.

Family Planning Provider
Public Health – Seattle & King County

Take Charge

ρ **Pending**

ρ **Approved**

ρ **Denied**

Take Charge Application Attempted, But Patient…..

ρ **Declined**

ρ **Not Eligible**

ρ **Has FP Insurance**

Renewal Date:_________________*(12 months from enroll)*

ECRR/Annual can be done_________________
(no sooner than 10 months after the last ECRR/Annual).

Take Charge

ρ **Pending**

ρ **Approved**

ρ **Denied**

Take Charge Application Attempted, But Patient…..

ρ **Declined**

ρ **Not Eligible**

ρ **Has FP Insurance**

Renewal Date:_________________*(12 months from enroll)*

ECRR/Annual can be done_________________

Take Charge

ρ **Pending**

ρ **Approved**

ρ **Denied**

Take Charge Application Attempted, But Patient…..

ρ **Declined**

ρ **Not Eligible**

ρ **Has FP Insurance**

Renewal Date:_________________*(12 months from enroll)*

ECRR/Annual can be done_________________
(no sooner than 10 months after the last ECRR/Annual).

Take Charge

ρ **Pending**

ρ **Approved**

ρ **Denied**

Take Charge Application Attempted, But Patient…..

ρ **Declined**

ρ **Not Eligible**

ρ **Has FP Insurance**

Renewal Date:_________________*(12 months from enroll)*

ECRR/Annual can be done_________________
(no sooner than 10 months after the last ECRR/Annual).

Take Charge

ρ **Pending**

ρ **Approved**

ρ **Denied**

Take Charge Application Attempted, But Patient…..

ρ **Declined**

ρ **Not Eligible**

ρ **Has FP Insurance**

Renewal Date:_________________*(12 months from enroll)*

ECRR/Annual can be done_________________
(no sooner than 10 months after the last ECRR/Annual).

Take Charge

ρ **Pending**

ρ **Approved**

ρ **Denied**

Take Charge Application Attempted, But Patient…..

ρ **Declined**

ρ **Not Eligible**

ρ **Has FP Insurance**

Renewal Date:_________________*(12 months from enroll)*

ECRR/Annual can be done_________________
(no sooner than 10 months after the last ECRR/Annual).

PHARMACY FACT SHEET
For TAKE CHARGE FAMILY PLANNING SERVICES

If you are a pharmacist, **you <u>do not</u> need to have a TAKE CHARGE Provider Number** to serve clients with a TAKE CHARGE Family Planning Medical ID card. You will use your usual billing practices for Medical Assistance Administration (MAA) family planning services. Reference: 01-53MAA attached.

The TAKE CHARGE Family Planning Medical ID card is good for one year. For pharmacies, it covers the same family planning related prescriptions and OTCs that are covered with the other DSHS Medical ID cards; i.e. "Family Planning Only", CNP, MNP, CHIP, and GA cards.

Pharmacies may provide:

- Prescription contraceptives;
  - Birth control pills
  - Emergency contraception (including Preven and Plan B)
  - IUD (including Mirena)
  - Injections (including Depo Provera and Lunelle)
  - Diaphragm or cervical cap
  - Patch (Ortho Evra)
- Covered Medications related to a birth control method

- OTCs without a prescription;
  - Male and female condoms
  - Contraceptive foam, jelly, gel, and suppositories
  - Please note: **not *all*** OTCs can be purchased with a Medical ID card
  - Amounts of OTCs will vary depending on pharmacy stock

If you have questions, please contact Provider Relations at: 1-800-562-6188

Please read the back of this card

Medical Identification Card

This Card Valid From: **7/1/01**
To: **7/1/02**

411 E Main Street
Anywhere, WA 09735

PATIENT IDENTIFICATION CODE (PIC) MEDICAL COVERAGE INFORMATION

Initials	Birthdate	Last Name	TB	Insurance	Medicare	HMO	Detox	Restriction	Hospice	DD Client	Other

TAKE CHARGE
FAMILY PLANNING
(Note: card may say TAKE CHARGE or TAKE CHARGE FAMILY PLANNING)

J.R. Public
123 Main Street
Anytown, WA 98000

SIGNATURE (Not Valid Unless Signed)

SHOW TO MEDICAL PROVIDER AT TIME OF EACH SERVICE

DSHS Medical Assistance Administration
Mary Neukom, Family Planning Program Manager
May 3, 2002

TAKE CHARGE

CLIENT PRE-APPLICATION WORKSHEET

AND

APPLICATION

Washington State DEPARTMENT OF SOCIAL & HEALTH SERVICES

TAKE CHARGE PRE-APPLICATION WORKSHEET

APPLICANT'S NAME LAST	FIRST	MIDDLE	DATE

SECTION I – MEDICAL NEED FOR FAMILY PLANNING

Male or Female Applicant

		Yes	No
1.	Do you intend to use a birth control method to prevent an unintended pregnancy? **If "no," you are ineligible for TAKE CHARGE. (Stop here; discuss payment for services with your provider.)**	☐	☐
2.	**Female Applicant** Do you have any reason to believe you could be pregnant now? **If "yes" or "don't know" (DK) stop here and ask for a pregnancy test. If pregnancy test is negative, continue to Section II.**	☐	☐

Don't know ☐

SECTION II – CITIZENSHIP AND RESIDENCY REQUIREMENTS

		Yes	No
1.	Are you a US citizen or US nationalist or a permanent legal resident that arrived in the US 5 years prior to the date of this application? (If "yes" continue to next question.) **If "no," you are ineligible for TAKE CHARGE. (Stop here; discuss payment for services with your provider.)**	☐	☐
2.	Are you a Washington State resident? (If "yes" continue to next question.) **If "no," you are ineligible for TAKE CHARGE. (Stop here; discuss payment for services with your provider.)**	☐	☐
3.	Are you from another state attending school in Washington State? (If "no", continue to Section III.)	☐	☐
	If "yes," do you intend to remain after your schooling is completed? (If "yes" continue to Section III.)	☐	☐
	If "no", you are ineligible for TAKE CHARGE. (Stop here; discuss payment for services with your provider.)		

SECTION III – HEALTH INSURANCE

		Yes	No
1.	Do you have a DSHS Medical ID card? **If "yes," you are ineligible for TAKE CHARGE. Your provider will bill MAA using your current PIC number.**	☐	☐
2.	Do you have health insurance that covers birth control methods and family planning? (If "no," continue to Section IV.) **If "yes," your insurance will be billed first.**	☐	☐

Exceptions:

If there is a reason you cannot use your health insurance for birth control/family planning services, check which reason applies.

☐ Teen (explain why; e.g. confidentiality) _____

☐ Domestic Violence

Continue to Section IV

SECTION IV – INCOME REQUIREMENTS FOR FAMILY SIZE

Monthly Earned Income

1.	Enter your GROSS wages, tips for the last monthly pay period. (Enter zero (0) if unemployed.)		
2.	If you are married, enter spouse's gross monthly wages.	(plus) +	
3.	Subtotal earned monthly wages.	(subtotal) =	
4.	Subtract $90 if you work and $90 if your spouse works.	(minus) -	
5.	Subtract any monthly work-related child or adult care payments.	(minus) -	
6.	Subtract all monthly court-ordered Child Support payments for a child living outside the home.	(minus) -	
7.	Total earned income.	**(Earned Income Subtotal)**	

8. You and Spouse's Monthly Unearned Income

	Amount		Amount
Child Support or Alimony		Veteran's Benefits	
Social Security Benefits		Labor & Industries Benefits	
Unemployment Benefits		Military Allotments	
Interest From Bank Account		Other	

9.	Total unearned income:	**(Unearned Income Subtotal)**	
10.	Total Monthly Income: (Use this amount on your application)	(Total of #7 and #9)	
11.	Family Size: (Include all family members living together and dependent on this income. Use this number on your application.)		

IF YOU MEET THESE REQUIREMENTS, COMPLETE THE ATTACHED APPLICATION

APPLICATION FOR WASHINGTON STATE
TAKE CHARGE FAMILY PLANNING SERVICES

Please print

LAST NAME	FIRST NAME	MIDDLE INITIAL

DATE OF BIRTH (M/D/YYYY)	☐ Male ☐ Female	SOCIAL SECURITY NUMBER

STREET ADDRESS WHERE YOU LIVE	CITY	STATE	ZIP CODE

MAILING ADRESS (IF DIFFERENT) or use Clinic address	CITY	STATE	ZIP CODE

☐ Confidential Address	If we need to contact you about your application, where may we contact you?	PLACE	TELEPHONE NUMBER

What language do you need for written information?

My total monthly income is: (Use the amount entered in Item #10 of the worksheet) _____

My family size is (Use the number entered in Item #11 of the worksheet) _____

DECLARATION AND SIGNATURE

I have read and understood the information in this application. I declare, under penalty of perjury:

- That I need contraception.
- That I am a Washington resident or a student that intends to remain in Washington after school.
- I am a U.S. citizen, U.S. nationalist, or a lawful permanent resident who arrived in the U.S. 5 years prior to the date of this application.
- I do not have health insurance available to cover birth control methods and family planning services.
- I have reported all my total monthly income.

All information I gave in this application is true, correct and complete to the best of my knowledge.

I also understand that if I am not eligible for the TAKE CHARGE program to pay for my family planning services, I need to make other arrangements to pay.

SIGNATURE OF APPLICANT	DATE

☐ I would like information about the other medical programs.

FOR CLINIC USE

NAME OF CLINIC/PROVIDER WHERE CLIENT IS APPLYING

NAME OF STAFF PERSON ASSISTNING CLIENT WITH APPLICATION	TELEPHONE NUMBER	FAX NUMBER

Disclaimer: This contraceptive Over-the-Counter (OTC) list is provided as a reference for what may be covered with a DSHS Medical ID card. MAA will update this list quarterly. Products listed may not be available on the date requested due to POS, federal rebate or FDA approval updates, or MAA Family Planning Program coverage limitations. *Always use the POS* system for payment status when clients' request OTC products with a DSHS Medical ID card. Printed flyers, brochures, and wallet cards may contain outdated OTC list.

OTC Contraceptives 3/10/03

Medical Assistance Administration

Name	Form	Strength	Package form	NDC
ATLAS	EACH		BOX	26893010002
ATLAS	EACH		BOX	26893010092
ATLAS	EACH		BOX	26893010102
ATLAS	EACH		BOX	26893010192
BECAUSE	FOAM/APPL.	8.00%	CAN	00085043901
BECAUSE	FOAM/APPL.	8.00%	CAN	00085043902
BEYOND SEVEN	EACH		PACKET	28373070003
BEYOND SEVEN	EACH		PACKET	28373070006
BEYOND SEVEN	EACH		PACKET	28373070012
BEYOND SEVEN PLUS	EACH		PACKET	28373090003
BEYOND SEVEN PLUS	EACH		PACKET	28373090006
BEYOND SEVEN PLUS	EACH		PACKET	28373090012
CAUTION CONDOMS	EACH		PACKET	30716016136
CAUTION CONDOMS	EACH		PACKET	30716040118
CAUTION CONDOMS	EACH		PACKET	30716080128
CAUTION CONDOMS	EACH		PACKET	30716080130
CLASS ACT	EACH		PACKET	22600091222
CLASS ACT	EACH		PACKET	22600091240
CLASS ACT	EACH		PACKET	22600091340
CLASS ACT	EACH		PACKET	22600091520
CLASS ACT	EACH		PACKET	22600091540
CLASS ACT	EACH		PACKET	22600091640
CONCEPTROL	GEL/PF APP	4.00%	PF APPLI	00062325001
CONCEPTROL	GEL/PF APP	4.00%	PF APPLI	00062325002
CONCEPTROL	INSERT	150MG	PF APPLI	00062325501
CONDOM	EACH		PACKET	63044003012
CONDOMS	EACH		PACKET	00536999512
CROWN	EACH		PACKET	28373020003
CROWN	EACH		PACKET	28373020012
CROWN PLUS	EACH		PACKET	28373031003
CROWN PLUS	EACH		PACKET	28373031012
DELFEN CONTRACEPTIVE	FOAM/APPL.	12.50%	CAN	00062313301
DELFEN CONTRACEPTIVE	FOAM	12.50%	CAN	00062313302
EMKO	FOAM/APPL.	8.00%	CAN	00085005001
EMKO	FOAM	8.00%	CAN	00085005002
EMKO	FOAM	8.00%	CAN	00085005003
EMKO	FOAM/APPL.	8.00%	CAN	00085005004
EMKO	FOAM/APPL.	8.00%	CAN	00085005005

EXTRA SENSITIVE	EACH	BOX	02340012800
FC CONDOM, FEMALE	EACH	PACKET	08388940305
FC CONDOM, FEMALE	EACH	PACKET	16169040303
FC CONDOM, FEMALE	EACH	PACKET	16169040305
FC CONDOM, FEMALE	EACH	PACKET	11423007000
FC CONDOM, FEMALE	EACH	PACKET	11423007070
GYNOL II	JELLY 2.00%	TUBE	00062318011
GYNOL II	JELLY 2.00%	TUBE	00062318012
GYNOL II EXTRA STRENGTH	JELLY/APPL 3.00%	TUBE	00062318501
HARMONIZE	EACH	PACKET	51709000605
HARMONIZE	EACH	PACKET	51709000606
HIGH SENSATION	EACH	BOX	02340007100
INTENSE SENSATION	EACH	BOX	02340008240
KIMONO	EACH	PACKET	16169001003
KIMONO	EACH	PACKET	16169001012
KIMONO MICROTHIN	EACH	PACKET	16169005003
KIMONO MICROTHIN	EACH	PACKET	16169005012
KIMONO MICROTHIN	EACH	PACKET	16169005024
KIMONO MICROTHIN PLUS	EACH	PACKET	16169006003
KIMONO MICROTHIN PLUS	EACH	PACKET	16169006012
KIMONO MICROTHIN PLUS	EACH	PACKET	16169006024
KIMONO PLUS	EACH	PACKET	16169003003
KIMONO PLUS	EACH	PACKET	16169003012
KIMONO SENSATION	EACH	PACKET	16169007003
KIMONO SENSATION	EACH	PACKET	16169007012
KIMONO SENSATION PLUS	EACH	PACKET	16169008003
KIMONO SENSATION PLUS	EACH	PACKET	16169008012
LIFESTYLES	EACH	BOX	70907001312
LIFESTYLES ASSORTED COLORS	EACH	PACKET	70907028030
LIFESTYLES ASSORTED COLORS	EACH	PACKET	70907028120
LIFESTYLES EXTRA STRENGTH	EACH	PACKET	70907021030
LIFESTYLES EXTRA STRENGTH	EACH	PACKET	70907021120
LIFESTYLES FORM FITTING	EACH	PACKET	70907019030
LIFESTYLES FORM FITTING	EACH	PACKET	70907019120
LIFESTYLES LUBRICATED	EACH	PACKET	70907015030
LIFESTYLES LUBRICATED	EACH	PACKET	70907015120
LIFESTYLES LUBRICATED	EACH	PACKET	70907015460
LIFESTYLES NON-LUBRICATED	EACH	PACKET	70907027030
LIFESTYLES NON-LUBRICATED	EACH	PACKET	70907027120
LIFESTYLES SPERMICIDALLY LUB	EACH	PACKET	70907018030
LIFESTYLES SPERMICIDALLY LUB	EACH	PACKET	70907018120
LIFESTYLES SPERMICIDALLY LUB	EACH	PACKET	70907018460
LIFESTYLES STUDDED	EACH	PACKET	70907024030
LIFESTYLES STUDDED	EACH	PACKET	70907024120
LIFESTYLES ULTRA SENSITIVE	EACH	PACKET	70907020120
LIFESTYLES ULTRA SENSITIVE	EACH	PACKET	70907017030
LIFESTYLES ULTRA SENSITIVE	EACH	PACKET	70907017120
LIFESTYLES ULTRA SENSITIVE	EACH	PACKET	70907017460
LIFESTYLES VARIETY	EACH	PACKET	70907029120
LIFESTYLES VIBRA-RIBBED	EACH	PACKET	70907016030
LIFESTYLES VIBRA-RIBBED	EACH	PACKET	70907016120
LIFESTYLES VIBRA-RIBBED	EACH	PACKET	70907014030

LIFESTYLES VIBRA-RIBBED	EACH	PACKET	70907014120
LUBE JELLY PLUS	JELLY 2.20%	TUBE	51672204104
MAXIMA LUBRICATED CONDOM	EACH	PACKET	17714011312
MAXX	EACH	PACKET	16169002003
MAXX	EACH	PACKET	16169002012
MAXX PLUS	EACH	PACKET	16169004003
MAXX PLUS	EACH	PACKET	16169004012
MENTOR	EACH	PACKET	22600064093
MENTOR	EACH	PACKET	22600064096
MENTOR PLUS	EACH	PACKET	22600064103
MENTOR PLUS	EACH	PACKET	22600064106
ORTHO-GYNOL CONTRACEPTIVE	JELLY 1.00%	TUBE	00062317009
REALITY	EACH	PACKET	41250052813
RIA LATEX CONDOM	EACH	PACKET	05632083010
RIA LATEX CONDOM	EACH	PACKET	05632083015
RIA LATEX CONDOM	EACH	PACKET	05632083020
RIA LATEX CONDOM	EACH	PACKET	05632083025
RIA LATEX CONDOM	EACH	PACKET	05632083030
RIA LATEX CONDOM	EACH	PACKET	05632083035
RIA LATEX CONDOM	EACH	PACKET	05632083040
RIA LATEX CONDOM	EACH	PACKET	05632083045
RIA LATEX CONDOM	EACH	PACKET	05632083050
RIA LATEX CONDOM	EACH	PACKET	05632083055
SAFE-LUV LUBRICATED CONDOMS	EACH	BOX	43820000301
SEMICID	SUPP.VAG 100MG	BOX	00573330109
SEMICID	SUPP.VAG 100MG	BOX	00573330118
TROJAN	EACH	PACKET	22600095000
TROJAN	EACH	PACKET	22600095100
TROJAN	EACH	PACKET	22600095250
TROJAN	EACH	PACKET	22600095850
TROJAN	EACH	PACKET	22600097250
TROJAN	EACH	PACKET	22600093850
TROJAN	EACH	PACKET	22600009340
TROJAN	EACH	PACKET	22600064712
TROJAN	EACH	PACKET	22600090750
TROJAN	EACH	PACKET	22600090950
TROJAN	EACH	PACKET	22600092050
TROJAN ENZ	EACH	PACKET	22600091050
TROJAN ENZ	EACH	PACKET	22600091950
TROJAN ENZ	EACH	PACKET	22600091750
TROJAN ENZ	EACH	PACKET	22600093050
TROJAN ENZ	EACH	PACKET	22600093070
TROJAN ENZ	EACH	PACKET	22600093150
TROJAN ENZ	EACH	PACKET	22600093170
TROJAN ENZ	EACH	PACKET	22600093250
TROJAN ENZ	EACH	PACKET	22600093270
TROJAN ENZ	EACH	PACKET	22600093350
TROJAN ENZ	EACH	PACKET	22600093950
TROJAN ENZ	EACH	PACKET	22600093750
TROJAN ENZ	EACH	PACKET	22600093770
TROJAN EXTRA STRENGTH	EACH	PACKET	22600099050
TROJAN EXTRA STRENGTH	EACH	PACKET	22600099150

TROJAN EXTRA STRENGTH	EACH	PACKET	22600099750
TROJAN EXTRA STRENGTH	EACH	PACKET	22600099850
TROJAN FOR WOMEN	EACH	PACKET	22600090820
TROJAN FOR WOMEN	EACH	PACKET	22600090840
TROJAN FOR WOMEN	EACH	PACKET	22600090620
TROJAN FOR WOMEN	EACH	PACKET	22600090640
TROJAN MAGNUM	EACH	PACKET	22600064203
TROJAN MAGNUM	EACH	PACKET	22600064212
TROJAN MAGNUM	EACH	PACKET	22600064503
TROJAN MAGNUM	EACH	PACKET	22600064512
TROJAN NATURALAMB	EACH	PACKET	22600098050
TROJAN NATURALAMB	EACH	PACKET	22600098750
TROJAN NATURALUBE	EACH	PACKET	22600097750
TROJAN NATURALUBE	EACH	PACKET	22600097950
TROJAN NATURALUBE	EACH	PACKET	22600097050
TROJAN PLUS	EACH	PACKET	22600091450
TROJAN PLUS	EACH	PACKET	22600091850
TROJAN PLUS	EACH	PACKET	22600092950
TROJAN PLUS 2	EACH	PACKET	22600096060
TROJAN PLUS 2	EACH	PACKET	22600096760
TROJAN RIBBED	EACH	PACKET	22600094050
TROJAN RIBBED	EACH	PACKET	22600094150
TROJAN RIBBED	EACH	PACKET	22600094550
TROJAN RIBBED	EACH	PACKET	22600094650
TROJAN RIBBED	EACH	PACKET	22600094750
TROJAN RIBBED	EACH	PACKET	22600094950
TROJAN SHARED SENSATION	EACH	PACKET	22600095950
NON-LATEX TROJAN SUPRA	EACH	PACKET	22600009340
TROJAN ULTRA TEX	EACH	PACKET	22600095640
TROJAN ULTRA TEX	EACH	PACKET	22600095740
TROJAN VERY SENSITIVE	EACH	PACKET	22600092220
TROJAN VERY SENSITIVE	EACH	PACKET	22600092240
TROJAN VERY SENSITIVE	EACH	PACKET	22600092320
TROJAN VERY SENSITIVE	EACH	PACKET	22600092340
TROJAN VERY THIN	EACH	PACKET	22600092620
TROJAN VERY THIN	EACH	PACKET	22600092640
TROJAN VERY THIN	EACH	PACKET	22600092720
TROJAN VERY THIN	EACH	PACKET	22600092740
ULTIMATE FEELING	EACH	BOX	02340007167

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Clinical Practice Guidelines for Treating Tobacco Use and Dependence
US Public Health Service Report: 2000

Conclusions:

1. Tobacco dependence is a **chronic condition** that often requires **repeated intervention**. Effective treatments exist that can produce long term or even permanent abstinence.

2. **Every patient who uses tobacco should be offered** at least one of these treatments:
   A. Patients willing to try to quit tobacco use should be provided treatments identified as effective.
   B. Patients unwilling to try should be provided a brief intervention designed to increase their motivation to quit (educate, reassure and motivate).

3. It is **essential** that clinicians and health care delivery systems **institutionalize** the consistent **identification, documentation and treatment** of every tobacco user seen in a health care setting.

4. **Brief tobacco dependence treatment is effective** and every patient who uses tobacco should be offered at least brief treatment.

5. There is a **strong dose-response relationship between the intensity of tobacco dependence counseling and its effectiveness**. Treatments involving person-to-person contact via individual, group or telephone counseling are effective and their effectiveness increases with intensity: length, number of sessions and total minutes of contact.

6. Three types of counseling and behavioral therapies are found to be especially effective:
   A. Provision of **practical counseling** (problem solving/skills training).
   B. Provision of **social support** as part of treatment.
   C. Help in securing **social support outside** of treatment.

7. **Numerous effective pharmacotherapies** for smoking cessation now exist. These should be **used with all patients** attempting to quit smoking. **Special consideration** should be given before giving pharmacotherapy with selected patients: those with medical contraindications, those smoking less than 10 cigarettes a day, pregnant, breastfeeding women and adolescents. **Five first line therapies** were identified: nicotine patch, nicotine gum, bupropion, nicotine inhaler, and nicotine spray. **Two second line** were identified to be considered for use when first line not effective: clonidine hydrochloride and nortriptyline hydrochloride.

8. **Tobacco dependence treatments are both clinically effective and cost effective relative to other medical and disease-prevention interventions**. As such, insurers and purchasers should ensure that **all insurance plans include** counseling and pharmacotherapy as a reimbursed benefit and **clinicians should be reimbursed** for providing tobacco dependence treatment just as they are for treating other chronic conditions.

Brief Strategies to Help the Patient Willing to Quit Tobacco Use: the "5 As"

Step 1: ASK: systematically identify all tobacco users at every visit. Expand the Vital Signs to include tobacco use and/or use tobacco use status stickers on all patient charts/indicate using electronic records or computer reminder systems.

Step 2: ADVISE: strongly urge all tobacco users to quit. In a clear, strong and personalized manner, urge every tobacco user to quit.

Step 3: ASSESS: determine patient's willingness to make a quit attempt

- If the patient is willing to make quit attempt at this time, provide assistance
- If the patient will participate in an intensive treatment, deliver such as treatment or refer to an intensive intervention
- If the patient clearly states he is unwilling to make a quit attempt at this time, provide a motivational intervention
- If the patient is a member of a special population (adolescent, pregnant smoker, racial/ethnic minority) consider providing additional information)

Step 4: ASSIST: help the patient with a quit plan. A patient's preparations for quitting:

- Set quit date
- Tell family and friends and coworkers about quitting and request understanding and support
- Anticipate challenges to planned quit attempt, particularly during the critical first few weeks. These include withdrawal symptoms.
- Remove tobacco products from environment. Prior to quitting, avoid smoking in places where you spend a lot of time.

Provide Practical Counseling

- Abstinence is essential
- Past quit experience, identify what helped and what hurt in previous quit attempts
- Anticipate triggers or challenges in upcoming attempt
- Alcohol can cause relapse: patient should consider limiting/abstaining while quitting
- Other smokers in household: patients should encourage housemates to quit with them or not smoke in their presence

Provide Supportive Clinical Environment while encouraging the patient in his quit attempt. "My office staff and I are available to assist you."

Outside Social Support

Help patient develop social support for her quit attempt in her environment outside of treatment. "Ask your friends to support you in your quit attempt."

Recommend the Use of Approved Pharmacotherapy (except in special circumstances) Explain how medications increase smoking cessation success and reduce withdrawal symptoms. The first line pharmacotherapy medications include bupropion hydrochloride, nicotine gum, nicotine inhaler, nicotine nasal spray and nicotine patch.

Provide Supplementary Materials

Readily available; culturally appropriate, from federal, state and nonprofit agencies.

Step 5: ARRANGE: schedule follow-up contact; either in person or via phone. Should occur soon after the quit date, during the first week. 2nd follow up contact within the first month. Further follow up as indicated. Congratulate success. If tobacco use has occurred review situation as learning process and ask for recommitment. Identify problems and potential challenges. Assess pharmacotherapy use. Consider referral to more intensive treatment as needed.

Common Elements of Effective Counseling and Behavioral Therapies for Tobacco Cessation

1. Practical Counseling: Problem Solving and Skills Training

A. Identify Triggers (internal states, activities or events) that increase the risk of smoking or relapse:
- Negative Affect
- Being around other smokers
- Drinking alcohol
- Experiencing urges
- Being under time pressure

B. Identify and practice coping or problem solving skills
- Learning to anticipate and avoid temptation
- Learning cognitive strategies that will reduce negative moods
- Lifestyle changes that reduce stress, improve quality of life or produce pleasure
- Learning cognitive and behavioral strategies to cope with smoking urges

C. Provide basic information about smoking and successful quitting
- Any smoking, even one puff, increases the likelihood of relapse
- Withdrawal typically peaks 1-3 weeks after quitting
- Withdrawal symptoms include negative mood, urges to smoke and difficulty concentrating
- The addictive nature of smoking

2. Provide caring support for patient (MET)

A. Encourage the patient in the quit attempt
- Note that effective treatments are now available
- Note that half the people who smoked have now quit
- Communicate belief in patient's ability to quit

B. Communicate caring and concern
- Ask how patient feels about quitting
- Directly express concern and willingness to help
- Be open to patient's expression of fears of quitting, difficulties experienced ambivalent feelings

C. Encourage the patient to talk about the quitting process
- Reasons the patient wants to quit
- Concerns or worries about quitting
- Success the patient has achieved
- Difficulties encountered while quitting

3. Help the patient find ongoing support

A. Train the patient in asking for support
- Show videotapes that model support skills
- Practice requesting social support from family, friends and co-workers
- Aid patient in establishing a smoke free home

B. Prompt support seeking
- Help patient identify supportive others
- Call to remind patient to seek support
- Inform patients of community resources such as hotlines

C. Arrange outside support
- Mail letters/call supportive others
- Invite others to cessation sessions
- Assign patients to be "buddies" for one another

Brief Strategies to Prevent Relapse

Minimal Practice Relapse Prevention

These interventions should be part of every encounter with patient who has recently quit.

Every ex-tobacco user should receive congratulations on any success and strong encouragement to remain tobacco free. Use open ended questions designed to initiate patient problem solving. "How has stopping tobacco use helped you?" Encourage patients' active discussion of the following topics:

- The benefits, including potential health benefits, of cessation
- Any success the patient has had in quitting, duration, reduction of withdrawal, etc.
- The problems encountered or anticipated threats to maintaining abstinence weight gain, depression, alcohol, other tobacco users in house

Prescriptive Relapse Prevention

These interventions are based on information obtained about specific problems the patient has encountered and may be delivered during follow-up contact or through a specialized clinic or program.

1. Lack of support for cessation:

- Schedule follow-up visits and telephone calls
- Help patient identify sources of support
- Refer patient to cessation counseling or support

2. Negative mood or depression

- If significant, provide counseling, prescribe appropriate medications or refer the patient to a specialist

3. Strong or prolonged withdrawal symptoms

- If the patient reports prolonged craving or other withdrawal symptoms, consider extending the use of approved pharmacotherapy or adding/combining medications to reduce strong withdrawal symptoms

4. Weight gain:

- Recommend starting or increasing physical activity; discourage strict dieting
- Reassure patient that some weight gain is common and appears to be self limiting
- Emphasize the importance of a healthy diet
- Maintain the patient on pharmacotherapy known to delay weight gain (bupropion and nicotine gum)

5. Flagging motivation/Feeling deprived:

- Reassure the patient that these feelings are common
- Recommend rewarding activities
- Probe to ensure that the patient is not engaged in periodic tobacco use
- Emphasize that beginning to smoke (even a puff) will increase urges and make quitting more difficult

General Guidelines: Prescribing Pharmacotherapy

1. All smokers trying to quit should receive pharmacotherapy except in the presence of special circumstances.

   Special consideration should be given before prescribing to:
   - Those smoking less than 10 cigarettes a day
   - Patients with medical contraindications
   - Pregnant/breastfeeding women
   - Adolescent smokers

2. First line pharmacotherapies are: bupropion, nicotine inhaler, nicotine patch, nicotine gum, nicotine nasal spray.

3. Choose among these first-line therapies based on:
   - Personal knowledge
   - Patient past experience and preference
   - Patient characteristics: depression, concerns regarding weight
   - Contraindications for selected patients

4. Lighter smokers (10-15) may use the pharmacotherapy, but at lower dose for NRT. No adjustments are necessary for sustained-release bupropion.

5. Second line pharmacotherapies are clonidine hydrochloride and nortriptyline hydrochloride.

6. Sustained-release bupropion and nicotine gum have been shown to delay weight gain.

7. Bupropion hydrochloride and nortriptyline hydrochloride appear to be effective in patients with a history of depression.

8. The nicotine patch is safe to use with patients with a history of cardiovascular disease. The safety of these products has not been established for immediate post-MI period or in patients with severe or unstable angina.

9. Pharmacotherapies may be used long term (6 months or more) with smokers who report persistent withdrawal symptoms. A minority of patients use NRT long term. The use of these long term does not present a known health risk. The FDA has approved the use of bupropion for long term maintenance.

10. Pharmacotherapies may be combined to increase long-term abstinence rates. Evidence supports use of nicotine patch with nicotine spray or gum to increase abstinence rates over those produced by a single form of NRT.

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Nicotine Patch Procedures for Family Planning Only Clinics

The Following are steps to take (it may vary from site to site) to implement the Nicotine patch for those patients interested:

- Assess tobacco use and readiness to quit with the *Tobacco Use Assessment Chart Note* (RN/MA complete #'s 1-7).
- Any patient interested in the patch should fill out the first page of the *Nicotine Patch Instructions* prior to seeing the Doctor or Nurse Practitioner.
- Nurse Practitioner or Doctor completes *Tobacco Use Assessment Chart Note* (#'s 8-10) and prescribes the patch.
- Patient signs the *Nicotine Patch Consent Form.*
- Patient takes the *Tobacco Use Self-Assessment* and *Nicotine Patch Instructions* home (these are on one sheet, two-sided).
- The *Consent* and *Tobacco Use Assessment Chart Note* are left in the chart.
- The *NRT Distribution Form* is faxed to Whitney Taylor at (206) 205-5670. Whitney makes the follow-up appointment, with the Medical Director or Chief of Pharmacy.

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

TOBACCO USE ASSESSMENT CHART NOTE

1. Form of tobacco used: □ cigarette □ cigar □ pipe □ chew
2. Packs/cans of tobacco used per week: _____
3. Number of previous attempts to quit: _____
4. Previous use of nicotine replacement: □ Yes □ No
5. Number of smokers in household: _____
   Current smoker: _____ Recent quitter: _____
   Review effects of environmental tobacco smoke: _____
6. Readiness to quit:

____ No interest in quitting (no plan to quit in the next 6 months) PRECONTEMPLATIVE
____ Not ready to quit (thinking about quitting in the next 6 months) CONTEMPLATIVE
____ Willing to learn about quitting READY FOR ACTION
____ Ready to quit in one month ACTION
____ Recent quitter (quit > 2 weeks but < 1 year) MAINTAINANCE

7. Patient is:
   a. < 18 years of age □ Yes □ No
   b. Pregnant □ Yes □ No
   c. Breastfeeding □ Yes □ No
   d. Allergic to nicotine patches □ Yes □ No

_____ _____ _____
RN/MA Signature RN/MA print name Date

8. Discussed risks and benefits of the nicotine patch associated with coronary artery disease, Arrhythmia, hypertension, diabetes, ulcers, liver, kidney, or thyroid disease. Patient has selected to proceed with use of the nicotine patch. □ Yes □ No □ N/A
9. Plan of action:
   _____ Provide nicotine patch (if all responses to #7 are "No" and ready to quit in one month) and refer to Community Cessation Partnership.
   a. Fagerstrom score is _____.
   b. Will use the ____ mg patch for _____ weeks.
   c. Dispensed four-week supply of _____ mg patch.
10. PHSKC NRT consent signed and placed in chart. □ Yes □ No

_____ _____ _____
Provider signature Provider print name Date

PATIENT LABEL

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Nicotine Patch Consent

1. I have received the Nicotine Patch Instructions.
2. I have had the opportunity to ask questions and my health care provider has answered them.
3. Nicotine patch side effects have been explained to me.
4. I understand that I cannot continue to use nicotine-containing products while using the nicotine patch.
5. I understand that I will need to use the nicotine patches for a minimum of six to eight weeks.
6. I understand that the first two to four week supply is available to me at no cost.
7. I can be reached at (____) _____ for follow-up support.
8. The best time(s) to reach me are at _____.

Patient Name (please print)	**Witness (please print)**
Patient signature **Date**	**Witness signature**

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Nicotine Patch Instructions for (Name) _____(Date)_____

How much do I need?
In order to assist your health care provider to determine the appropriate starting dose, please answer the following questions[1]:

1. How soon after you wake up do you smoke your first cigarette?

Within 5 minutes	3 points
5-30 minutes	2 points
31-60 minutes	1 point
after 60 minutes	0 points

2. Is it hard for you to not smoke in places where it is forbidden such as in church, at the library, in a movie, in court, in the hospital, etc.

Yes	1 point
No	0 points

3. Which cigarette would you hate most to give up?

The first one in the morning	1 point
Any other one	0 points

4. How many cigarettes do you smoke each day?

10 or fewer	0 points
11 – 20	1 point
21 – 30	2 points
31 or more	3 points

5. Do you smoke more during the first hours after waking up than during the rest of the day?

Yes	1 point
No	0 points

6. Do you still smoke if you are so sick that you are in bed most of the day?

Yes	1 point
No	0 points

Total…… _____ points

Score	**Start with**
7-10	21 mg patch
4-6	14 mg patch
<4	7 mg patch

[1] Fagerstrom Test for Nicotine Dependence

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

How do I use the nicotine patch?

1. Only open the sealed package when you are ready to put on a patch.
2. Peel the protective cover off the patch and throw it away. Try not to touch the adhesive side of the patch.
3. Put one patch on a dry area of skin without hair, such as your stomach, upper arm or side. Do not put the patch on burned, cut or sore skin.
4. To apply the patch, place the silver side on your skin and press it firmly in place for about 10 seconds with the palm of your hand. Make sure the patch is flat and smooth against your skin.
5. Wash your hand after putting on the patch.
6. Wear the patch for the amount of time shown on the package. Most patches are worn for 16 to 24 hours. Put the next patch in a different place on your skin. You should be able to use the same spot on your skin after about 1 week.
7. When you take off the old patch, fold it in half with the sticky sides together. Put the used patch in the package from the new patch, then place the package in the trash, where children or pets cannot reach it.
8. Read carton and user guide that comes with product. Keep the carton and user's guide for future reference.
9. Complete the full treatment program as discussed with your health care provider.
10. Refrain from using tobacco products using the patch.
11. During the course of treatment your health care provider will adjust the strength of the patch.
12. You will need to cut the 14 mg patch into two when it is time to use the 7 mg patch.

Are there any side effects?

While using the patch, you may experience headaches, insomnia, dizziness, anxiety, irritability, fatigue, stomach upset, diarrhea or constipation. Some of these side effects may be from nicotine withdrawal. You may need to adjust your dosages. Consult your provider.

Do not continue to smoke while using the patch. It will greatly reduce your chance to succeed in quitting. Nicotine overdose is possible.

It is normal to experience itching, burning or tingling when you first apply the patch. This reaction should disappear within 1 hour. After removing the patch, the skin underneath may remain somewhat red for up to 24 hours. If the skin becomes swollen or very red or you develop a rash, remove the patch and consult your health care provider. You may be allergic to one of the components of the patch.

How can I increase my chances for success?

1. Stop smoking completely while using the patch.
2. Identify and use patient support programs.
3. You must be motivated and committed to quit before you start.

Questions?

Call Whitney Taylor at (206) 205-5818, or the Quit line at 1 877 270 STOP

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Community Tobacco Cessation Partnership

FAX

NRT Distribution Form

Please complete this form for each box of NRT dispensed and immediately fax to Whitney Taylor at Public Health - Seattle & King County at Fax Number (206) 296-0177

Date: _____

To: WHITNEY TAYLOR – Public Health – Seattle & King County

From: Provider Name: _____ Clinic: _____

Client Information:

Client's Name:_____

AGE: _____

ID #: _____

Treatment Plan:

_____mg of NRT for first two to four weeks. Start Date: _____

Comments:

_____

_____

_____

ARE YOU BURDENED BY YOUR TOBACCO USE?

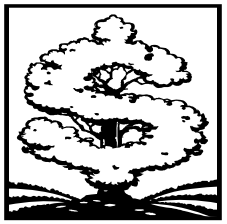
SUPPORT GROUP

Available for *tobacco users* who want to quit

For information and location call Whitney at 206-205-5818

DO YOU WANT TO QUIT SMOKING?

Is your money literally going ***up in smoke***?



Cessation services available

ASK YOUR PROVIDER